Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08-09-99

Physician /Medical Examiner

Funeral Director

Director

Funeral

by

Be

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examine must be notified at Hygiene. s 1 and 2 should be fit If Health and Mental H Nem 27 Is marked off Pages 1 and 2 should permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra

Physician /Medical **Examiner** Physician/Medical Examiner

The law requires that the deeth certificate be executed attending physician and for use as the bunel-tran Box 68760 P.O. signed by the Division of Vital Records, After this certificate Hospital or Attending Physician: death. I Director: A To the Hospital o within 24 hours of To the Funeral Di completely filled in

þ

Completed

Be

2

Certification:

Medical

· aurelio C. de letos, pe.D.

AURELIO C. DELAPAZ M.D.

31. Date filed (Month, Dey, Yeer)
AUG 1 1 1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day HENRY LOUIE BARBOUR AUGUST 9,1999 12:45 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death LAPLATA CHARLES CIVISTA MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JUNE 9, 1912 Birthplace (State or Foreign Country)
 MARYLAND If Under 1 Year 7. Age (In vrs. lest birthdav) 5. Social Security Number 6. Sex 1**∑** M 2□ F Months Days 212-14-3992 87 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Ves 2 No CHARLES BRYANS ROAD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3200 LIVINGSTON ROAD P.O. BOX 112 20616 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ANo If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CRAIN OPERATOR GOVERNMENT 6 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) WILLIAM HENRY BARBOUR BLANCHE DILLIE MARBURY BARBOUR 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY BARBOUR/WIFE 3200 LIVINGSTON ROAD, BRYANS ROAD, MARYLAND 20616 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuria1 2 ☐ Cremation 3 ☐ Removal from State ST. CHARLES CEMETERY 8/13/99 GLYMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility LESN THORNTON THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON RD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting In death) CONGESTIVE HEART FAILURE 12 days Due to (or es e consequence of): CORDNARY ARTERY DISEASE 2-3 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury HYPERTENSION 4ears that Initiated events resulting in death) Last Due to (or as a consequence of): ARTERIOSCLEROSS Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GOUT 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Melnutrition due to inanitron PLEURISY GASTRICULCERS ANEMIA 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medicel examiner? 26. Piece of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manne of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

D-16160

128 ROUTE 6 WEST P.O. BOX 1230 LAPLATA MD. 20646

State Registrar

AUG 1 1999 /6--- A

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Rola	and Brew	ster	State of Marylar		artment of			iene	2 2	7002
	Dhusisian	1. Decedent'a Name (First, Middle, Last)					2. Date of Deal		Year	3. Time of Death
	Physician /Medical	Roland Da	arol Brews	ter			August	08	1999	05:42 AM.
	Examiner	4a Facility Name (If not institution, give str		1 0 1			n, or Location of Death	4c. County		
			ge's Hospita				verly			orge's
	Funeral Director	5. Social Security Number 219-13-8976 Usuat Residence of Decedent	7. Age (In yrs	9 Yrs.	Months Da		Min. 8. Date of Birth (Month, Day)		9. Birthpla Country 1ary 1	ca (State or Foreign y) and
with the Manhan	and ahow	Md. 10b. County Prince G		Rive	rdale				100	d. Inside City Limits 1 X Yes 2 ☐ No
di di	or items 23s or 28s-f show miner must be notified at 7 Funeral Director	10e. Street and Number 5703- Quintana	Street		10f. Zip Cod 2073		1	0g. Citizen of W USA	Vhat Country	y?
5-0020	ar, or hems tramfore m by Funer	11. Marital Status 12 11. Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C		n? (Specify Yes or No- Puerto Rican, etc.)	Biac	- American k, White, et Whit	ic.
21215-0020		15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) Coilege (1-4or 5+)	16a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use re	cupetion ne during most o tired)	of working	16b. Kind of Bu	siness/Indu	stry
	Comp	12		Com	puter	Specia			npute	r
pu a	Be Vot	17. Father's Name (First, Middle, Last)				18. Mother's	Neme (First, Middle, I		,	
Z a	Men dc	Roland D. B.					Mavis M.			
Maryland	9 4 5	19a. Informant's Name/Relationship (Type Roland D. Brews					or Rural Route Number			
	Department of Health Important: If Idem 27 any Injury or other tr once.	20a. Method of Disposition			sition (Name of			20c. Location -		
Baltimore,	To I o	1 ☐ Burial 2XCC remation 3 ☐ Rer	novai from State	cemetery, crei	matory or other	placa)				
Itin	Department Important: I any Injury o	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral article Licensee				dress of Facility	ory-8/10	Alexar	laria	, va.
Balt	Depa Impo eny l	1 JIV .M			IIII	na Co	,Inc.Fune	ral Ho	ome	
، کر	hysician /Medical xaminer	23a. Part1. Enter the disease of complex shock, or heart failure. Let only one Immediate Cause (Final disease or condition resulting in death)	PULMOUSRy		ow BDE	1		est,		Approximate nterval Between Onset and Death
ords, P.O. Box 68760, requires that the death cardicate be executed	d by the attending physicien and letached for use as the bunel-transit Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consector as a consec	quence ot):	troingo?	513			
G. Bear	the attend for the ysicia	Part II. Other aignificant conditions contri	buting to death but not re-	sulting in the u	nderlying cause	given in Part I.	23b. Did to	bacco usa cor	ntributa to t	the cause of death?
S, P.O.	signed by the attending to be detached for use detached for use debt.	Morpio obssi	7				1 U Y	ea 2□ No	3 ☐ Probe	ably 4 Unknown
9 *	10 00						24a. Was a parfon	n autopsy med?	avail	e autopsy findings lable prior to pletion of cause eath?
E P	certificate has rector, page 2						150	es 2□No	1 🗀	Yes 2□ No
Vita	s certific director.	25. Wes case referred to medical examiner?	spital:				f Death (Check only on	18)		
Division of Vital	9 5	27. Manner of Death 1 Stretural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time o Injury	28c. I	Other: 4 Nurs njury at Work? 1 Yes 2 No	28d. Describe he			
Division	after death. I Director: After tiled in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Piaca of Injury - At h building, etc. (Speci	iome, ferm, sti fy)	eet, factory, offi	ice	28f. Location (SI City or Town	treet and Numb n, State)	er or Rural i	Route Number,
To the Hospit	4 hourself files of files	(Check only one) 2 (2) Medicat Examine	lan: To the best of my knor: On the basis of examina and manner stated.	owledge, death ation and/or in	vestigetion, in m	ny opinion, death	occurred at the time, d	ate and placa,	and due to t	the cause(s)
P	To the com	29b. Signature and title of certifier	20 N- 10	. 1	29c. Lic	ense number	2	9d. Date signed	d (Month, D	ay, Year)
	1	manine 103	e your	w		.C.M.E.		Augus	t 9,	1999
-	6		KONSIL1 Penr	Stree		imore, M	Maryland 21	201		
	State Registrar	31. Date filed (Month, Day, Year) AUG 1 1 1999	32. Registrar's Sign		Long	81				

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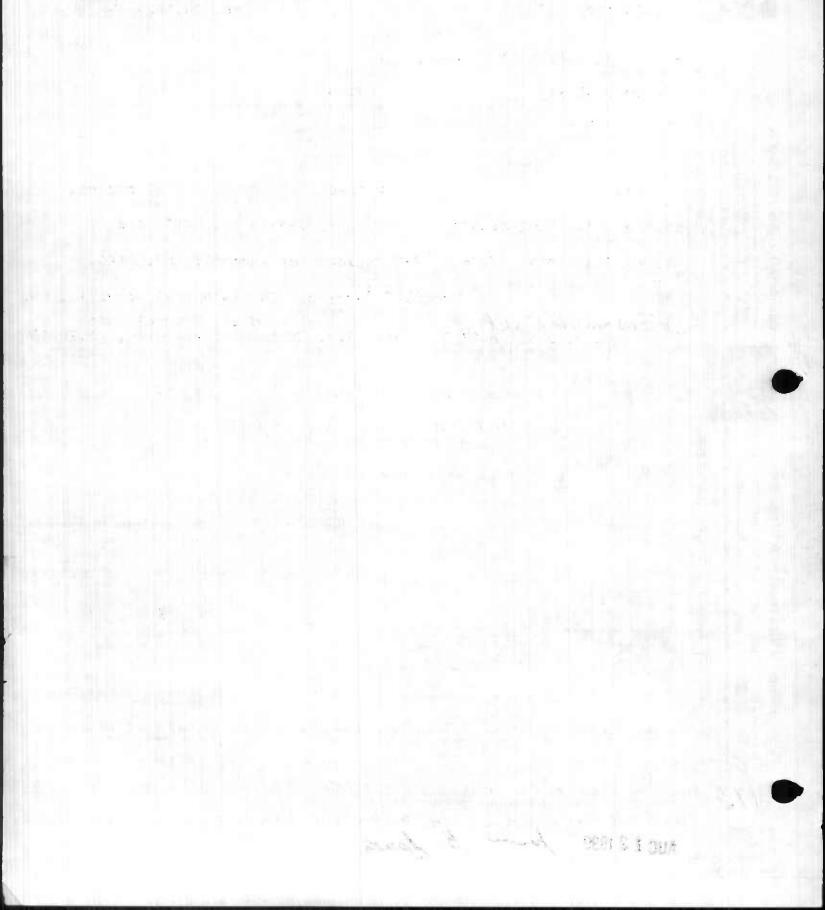
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State of Maryland / Department of Health and Mental Hygiene 99 27003

Provided					Cert	tificate of	Death	-	Reg. No.	10	
Examiner Examin			1. Decedent's Name (First, Middle, Las	t)							f Death
Anne Arundel Medical Center Anne Arundel Medical Center Anne Arundel Medical Center Social		•	ERNEST	BIGGE	RSTA	FF					8AM
S. Source Security Numbers S. Source Secu						4	b. City, Town, or Lo			of Death	
Direction 239 - 34 - 1199 130 to 20 F 70 70			Anne Arundel	Medical Cen	ter	P	nnapoli	S		Arundel	
The State of Number 100 Cody, Town or Location 102 Not Number 100 Cody, Town or Location 110, Other and What Country? No. State of Number 100, State and Number 100, State of Number 110, Other and What Country? 100, State of Number 110, Other and What Country? 110, State December of Number 110, State December 110		Funeral					Hours Min	(Month, Da	v. Year)	GOVIDIOV) + 1	
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Note that the state of the stat		the the		undel An	mapoli	T			10a. Citizen of V	/hat Country?	
New Character Specify		With With	926 Topmast Way	17							
Note that the state of the stat		Tre 2:	-	12. Was Decedent Ever in	U,S. 13. W			city Yes or No			
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The property of the property	21	giene giene graft vr the			E	ngineer			Ele	ctrical	
Ary W. Biggerstaff/Wife 926 Topmast Way Annapolis Md. 21401 20c. Location - City or Town, State 20c.	pu	othy vent	17. Fether's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumam	e)	
Ary W. Biggerstaff/Wife 926 Topmast Way Annapolis Md. 21401 20c. Location - City or Town, State 20c.	yla	Ment Ment Ment Ment Mice To	Ernest F. B.	iggerstaff			Jennie	Μ.	McGinn	is	
A Docasion S Other (Specify) Memorial Cardens O8-14-99 Davidsonville, Md.	lan		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street	and Number or Rura	I Route Number	er, City or Town,	State, Zip Code)	
A Docasion S Other (Specify) Memorial Cardens O8-14-99 Davidsonville, Md.		and ealth n 27		taff/Wife	926	Topmast	. Way An	napoli	s Md.	21401	
A Docasion S Other (Specify) Memorial Cardens O8-14-99 Davidsonville, Md.	ore	of H		Removal from State	Piaca of Dispos	ition (Name of atory or other plac	ce)	Date	20c. Location -	City or Town, State	
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Physician / Medical Examiner Physician / Medical Examiner	Sall	epart epart nport ny In	21. Signature of Funeral Service Licens	2.00	22.	Name and Addre	ss of Facility	eall F	uneral	Home	
23. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infeative Between Onset and Death Physician Middleal		405 # 9	Shannon W. Be	eall M00798	65	12 N.W.					715
Physician Medical Examiner		1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de	ath. Do not ente	r the mode of dyir	g, such as cardiac	or respiratory a	rest,	Approxima Interval Be	ite itween
Gesease of condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate growing and the conditions of the conditi				,						Onset and	Death
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Natural September Septembe	>	s cert direct	exeminer?	Hospital: 101 Innationt 2	☐ FR/Outpatient	3 DOA Oth	or.			er (Specify)	
29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)		ereli		28a. Date of Injury	28b. Time of						
29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)	0	ath. e fun		(WOHIII, Day rear)	injury						
29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)	Vis	Afte ecto ecto by the	dotomined	28e. Piaca of Injury - At	home, farm, stre	et, factory, office		28f. Location (Street and Numb	er or Rurel Route Nur	nber,
29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)	ō	S office	4 110111000	building, etc. (open	ony)			ony or vo.	m, otato,		
29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)		hour hour hy fill cai	29a. Certifier 1 Certifying Phy	relcian: To the best of my ki	nowledge, death	occurred at the tir	ne, date and piace,	end due to the	cause(s) and ma	nner as stated.	(e)
29b. Signature and title of cartifler 29c. License number 29d. Date signed (Montin, Day, Year)		In 24	ane)		TATION AND OF INVI						-)
The Kandle MD D50016 Engust 11, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA ALEXANDER GH FRANKLIN STREET ANNAPOLIS MODILION		0 100	29b. Signature and title of cartifier				/				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA ALEXANDER GH FRANKLIN STREET ANNAPOLIS MODILLO		111	Pellexand	er MD		D5	0016		dugu	st 11,19	99
BARBARA ALEXANDER GH FRANKLIN STREET ANNAPOLIS MODILLO		(18)	the state of the s		em 23a) (Type, F	Print)			0		
			BARBARA ALEXA	ANDER G	OH FR	ANKLI	V STRE	ET.	ANNAF	OLIS MI	2140

Registrar



Please Type or Print in Black Indelible Ink.	Assure All Copies Are Legible.
Chata of Mandand / Danadmant of Li	selth and Montal Husiana

			Certificate of Death	,	Reg. No.	27004
1	Dhiir		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Dey Yea	3. Time of Death
	Physi /Me		LUCY BUTLER	AUGUST	17,1999	1:48 AM
	Exan			r Location of Deatl		ath
7			CIVISTA MEDICAL CENTER 5 Social Security Number	CA	CHARLES	inh days (Otata as Cassian
	Funera Directo	_	5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. lest birthday) Yrs. 1 Months Days Hours Mi Usuel Residence of Decedent	Month, De	23,1904	irthplece (State or Foreign Country) Onio
	and land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Meryland r 28a-f ahow	tor	MD Charles La Plata			1 X Yes 2 □ No
	h the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	th wit	<u></u>	10200 La Plata Road 20646		USA	
	itams itams	Funeral	11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forees? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexicen, Pure	(Specify Yes or No orto Ricen, etc.)	- 14. Race - Ar Bleck, WI	nerican Indian, nite, etc.
21215-0020		by	If Yes, Give 1 ☐ Yes 21 ☐ No Specify:		Specify:	White
L.	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed] [Ife. Do NOT use rating)	vorking	16b. Kind of Busines	ss/industry
121	within then	ldm.	Elementary/Secondery (0-12) College (1-4or 5+) Supervisor		Federal	Govt
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Maryland	A D D A	To Be		rooks C	arpenter	
) 2	d 2 should th end Men 7 la marke traumatic	-	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or	Rural Route Numb	er, City or Town, State	, Zip Code)
- 6	2 6 6 7		T. Jean Conge/Guardian 2674 Pinewood Dr.	Waldor	f, MD 206	501
97			20e. Method of Disposition 20b. Plece of Disposition (Name of camelery, cremetory or other place)	Date	20c. Location - City	or Town, Stele
E	Pages ment of I		4 Donetion 5 Other (Specify) Soldiers Home National	Cem.8/	20/99 Was	shinton DC
Ralfimore	permit. Pages Department of Important: If i any Injury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	THE PARTY AS	I HOME D	
_	4 405 6	3	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	A PLATA	MD 20646	
			23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iec or respiretory e	frest,	Approximate interval Between Onset and Deeth
	Physicia /Medica		Immediate Cause (Fine)	80.1.	7.	200
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	certific ding p		resulting in death) Last Output (or es e consequence of):	elior	•	waly
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O	t the d	hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.		•	Probably 4 Unknown
	s that	by P	During , Coronary away			
of Vital Records	Attanding Physician: The law requires that the death cer and death. The law requires that the death cer actor. After this certificate has been signed by the attendire by the funeral director, page 2 should be detached for use	Completed		24e. Wes	en eutopsy ormed?	b. Were autopsy findings available prior to completion of cause
29.0	has b	mpl	1 le mentere			of deeth?
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Division	To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A completely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (City or To	Street and Number or wn, Stete)	Rural Route Number,
-	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	S C	29a. Certifier 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pie	ce, end due to the	cause(s) and manner	as stated.
	n 24 h	edical	(Check only one) 2 Medicat Examiner: On the basis of exemination and/or investigation, in my opinion, death or and manner stated.	curred at the time,	date end plece, and o	lue to the cause(s)
	To the To the Company	Σ			29d. Date signed (Mo	onth, Dey, Year)
			D-08370		8/17/	199
			30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)			
			PAUL E. PRITCHETT M.D. 118 LAGRANGE AVENUE P.O. BO	x 1317 I	APLATA MD.	20646
-	S Regis	tate trar	AUG 1 9 1999 Days & South			

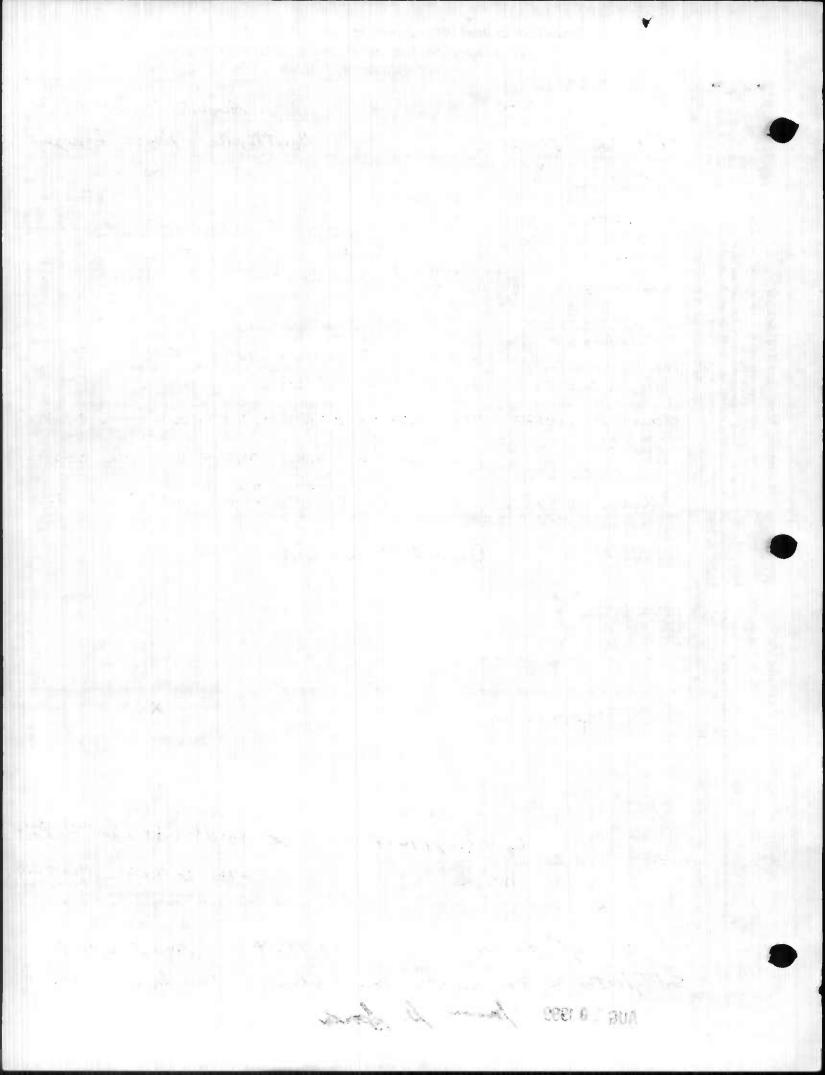
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State of Maryland / Department of Health and Mental Hygiene

	Decedant's Name (First, Middle, L.)	not)		Certifica	ate or	Dealli	2. Date of Dea	Reg. No.	2 Tim	e of Death
Physician	Neale Kenneth	Campbell					Month	Day	Yaar / /	700
/Medical Examiner	4a Facility Nama (If not institution, gir					4b. City, Town, or I	Location of Death	4c. County		
L.Xuiiiiiiiiiiii	4735 68 1	Place				Hyatt.	Tville	Princ	e Geor	ces
uneral rector	212-54-1923	Sex 7. Ag	ge (In yrs. last i 51	Yrs. If United Month	der 1 Yaar ns Days	if Under 24 Hrs. Hours Min.	8. Data of Birt (Month, Da) July 2	Year) 4, 1948	9. Birthplace (Ste Country) Maryland	te or Foreig
show	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					10d. Inside	a City Limits
nottled at rector	Maryland Prince	George's	Hyatts	sville					101	Yes 2 No
or 28 sendt	10e. Street and Number			10f.	Zip Code			10g. Citizen of \	What Country?	
23a math	4735 68th Place			20	784			U.S.A.		
natural", or frame 23a or 28a-f s president must be notified eted by Funeral Director	11. Marital Stafus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1 X Yes 2 I If Yes, Giva Year or Dates:	No	1 ☐ Yes	cedent of the pecify Cub.	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yas or No- o Rican, etc.)	Blac	e - American Indiar ck, White, etc. White	1,
nt, tre Medical i	15. Decedent's E (Specify only highest gr	ducation ede completed)	16	Sa. Decedent's U	suai Occup work done	eation during most of world)	king	16b. Kind of B	usiness/Industry	
omo	Elamantary/Secondary (0-12)	College (1-4or	5+)	Auto Mec	hanic			Private	Industry	у
Be C	17. Father's Nama (First, Middle, Las	t)				18. Mothar's Nar	na (First, Middle,	Melden Sumen	18)	
ToE	Robert A. Campbe	11				Shirley	A. McWi	lliams		
traumetic	19a. Informant's Name/Ralationship					end Number or Ru				00600
other tr	Kathleen Ann Cam	pbell - Wi		of Disposition (f		nt Road,	Hunting		laryland 2	
injury or of	20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Content		ceme	politan	r other ple				City or Town, State	
once	21. Signature of Funeral Service Lice	nsee		Gasc	h's F	ss of Facility uneral H			le, MD 20	721
buriel-transit and and all Examiner	immediate Cause (Final disease or condition resulting in death)	a	Due to (or as	a consequence of	of):	md				
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last	c		a consequence o					†	
clan/N							1			
by Physician/M	Part ii. Other eignificant conditions	contributing to death b	out not resulting	in the underlyin	g cause gi	ven in Part I.	23b. Did 1	~	ntribute to the ceu 3 ☐ Probably	4 Unknov
etec								an autopsy mad?	24b. Ware autop available pr complation of daath?	rior to
omb							10	res anno	1 □ Yes	2 No
rector, page	25. Was case raferred to medical examiner?					26. Placa of Da	ath (Check only o	ne)		
T di	10 Yas 2□ No	Hospital: 1 ☐ Inpati		Outpatient 3	DOA		lome 5 Resid	tence 6 □Ott	er (Specify)	
fune Lon	27. Mannar of Death 1 Natural 5 Panding 2 Accidant Investigatio 3 Sur Suicide 6 Could not be	1.1.2	y Year)	742 AM	28c. Inju Wo 1 🗆	y at rk? Yas 2 No	4000 Describe	Left	side of	cles
completely filled in by the funeral Medical Certification:	4 Homicide datarmined	building, et	c. (Specify)	farm, street, fac			4735	m. State	- Me	Number, 4 tryill
To the Funeral Director: completely filled in by the Medical Certifical		hyelclan: To the best miner: On the basis o and manner st	f examination							se(s)
Me Me	29b. Signature and title of certifier	and manner st			29c. Licans	a number		29d. Date signe	d (Month, Day, Yes	ar)
0	1 18 18	eta do			/	211804		Aug. 1	- 6/99	9
),	30. Name and addrass of person who	710				770		, feed	1	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 27006

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					Ce	ertificate o	of Death	F	leg. No.	- Eran	1000
6	400	_	1. Decedent's Neme (First, Middle, Last,)				2. Dete of Dee Month	ith	Year	3. Time of Deeth
	Physicia /Medica	_	DEBORAH INAB	NET CORE	BETT			August	6 19	999	2130
Ŷ.	Examine	_	4e Fecility Neme (If not Institution, give	street end number)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
			7235 G. Street				Seat Ple		Princ		
	Funeral Director		5. Sociel Security Number 6. Security Number 247–56–3890	3 44 - 600 =	yrs. last birthde; 66 Yrs.	Months Day			1933	9. Birthple Count South	eca (Stete or Foreign (ny) Carolina
	ehow		10e. State 10b. County	100	. City, Town or I	Location				10	Od. Inside City Limits
	death with the Maryland	Į.	Maryland Prince G	eorge's	Seat P	leasant					1 X Yes 2 ☐ No
	or 28a-f	Director	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of V	Whet Count	iry?
	th wit	2	7235 G Street			2074	3		U.S.A	•	
020	urs after	by Funeral	11. Maritel Stetus 1 ☐ Never Merried 2 ☐ Merried 3 🌣 Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	In U,S. 13	Wes Decedent of It Yes, specify C	of HispenIc Origin? (Stuben, Mexican, Puerl No Specify:	pecify Yes or No- to Rican, etc.)		e - America ck, White, e /: Bla	etc.
5-0	72 hours natural', olcal Ex	000	15. Decedent's Edu (Specify only highest gred	cation	16e. Dec	edent's Usuel Oc	cupation	rkina	16b. Kind of Bu	usiness/ind	ustry
Maryland 21215-0020	c 1 4 4	Сощрієте	Elementery/Secondary (0-12)	College (1-4or 5+)		b Techni	ne during most of wo lired) Cian		Gover	nment	
and	47.52	0	17. Fether's Neme (First, Middle, Last) Theodore R. Inab	inet				me (First, Middle, line St		ne)	
Z	s should be and Mental s marked o	0	19a. Informent's Name/Relationship (Ty		19h Me	iling Address (Str	eet end Number or Ri			Stete. Zip	Code)
M	alth an 27 is or trau		Deborah A. Theodo				Anne Roa				
e,	- 2 5 4	-	20e. Method of Disposition	20	b Plece of Dis	position (Neme of emetory or other		08/14	20c. Location -		
E	Pages ant of nt: If it		1 Burlel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)			ction Ce		1999	Clinton	n. Mar	cyland
Baltimore,	permit. Pages Department of Important: If is any injury or page.	ı	21. Signeture of Funerel Service Licans			22. Name end Ad	dress of Fecility			, , , , ,	J
0	SSEES	1	Nameur A	P	, 7	474 land	NKINS FUNE dover Road	Landov	er Mar	vland	20785
		7	23a. Pert1. Enter the disease, or compleshock, or heert feilure. List only of	icetions thet caused the	deeth. Do not e	nter the mode of	dying, such es cardia	c or respiretory er	rest,	yrano	Approximete Interval Between
J	Physician	1	Groot, or reservoires. Else only of	to out to out in to.							Onset and Deeth
4	/Medical Examiner	Н	Immediate Cause (Final disease or condition	CONG	ESTVE	HEA	PR FR	HURE			
и	E 16 4 4		resulting In deeth)		to (or as e cons					ĺ	
	D ====================================			ITYPE	rten!	N012					
•	death certificate be axecuted e attending physician and of or use as the burial-transit	edical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury		to (or es a cons		-1			i	
68760,	physician the buria	20	Cause. Enter Underlying Ceuse (Disease or Injury thet initiated events	MORB	to (or es e consi	OBES	m				
	ing physical east the		resulting in deeth) Lest	Due	o (or as a consi	equence oi).					
Box	attendin for use	SILV IM		i							
	e daat the att hed fo	200	Pert II. Other significent conditions cor	ntributing to deeth but not	resulting In the	underlying cause	given in Pert I.	23b. Dld 1	obacco use co	ntribute to	the cause of death?
, P.O	that the death cer ned by the attendir s detached for use	Completed by Physician	Maric	PERRERS	IVE	PISOR	DER	10	Yaa 2□ No	3 Prob	pably 42 Unknown
ords	v requires that been signed t should be det	nané							en eutopsy med?	eve	ere autopsy findings eilable prior to mpletion of cause
3ec	has b	du							1	of c	deeth?
a	defan: The Lector, page							101	es 2 No	10	Yes 2010
N N	Physician: this certific ral director,	0	25. Was case referred to medical examiner?	lospitel:			Othor	eth (Check only o			
o	Phys ral di	2	27. Manner of Deeth	1 L Inpatient	2 ER/Outpati	ent 3LI DOA	4 LI Nursing	dome 5 Di Resid	lenca 6 □Oth		0
on	Attending F r death. ector: After by the funar	0	1 Naturel 5 Pending Investigation	28e. Dete of Injury (Month, Dey Yea	r) Injury		njury et Work? I □ Yes 2 □ No				
Division of Vital Records,	frar death. Nirector: A in by tha fu	Cer IIII Callon.	3 Suicide 6 Could not be determined	28e. Pleca of Injury - building, etc. (Sp	At home, ferm, :	street, factory, offi	ca	28f. Location (3 City or Tox	Street and Numl yn, Stete)	ber or Rure	I Route Number,
		anical of		atclan: To the best of my ner: On the bests of exar							
	ithin 2 the smple	- 1	29b. Signeture end title of cartifier	end menner stated.		29c. Lie	ense number		29d. Date signe	d (Month. I	Day, Year)
	F3F8		Mehuse 2	Pere	MO		41146		and the same of		0, 1959
	1121		30. Neme end eddress of person who co			e, Print)	took Son	04.	44.0		
	()		RIODA A	PEAL	52	s scu	roor 20	7.W	14101	w	DO HER

DHMH 16 Ray 6/95

State

Registrar

31. Dete tiled (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene 99 27007

			Certificate of Death	Reg. No.	2. 1001
		1. Decedent's Nama (First, Middle, Last)		2. Data of Death Month Day Ye	3. Time of Death
	Physician /Medical	ANNIE MAE CARWED	<u>'</u> _	8 - 7 - 9	9 12-05A
	Examiner	4a Facility Name (If not institution, give street and number) GOLDEN OAKS NURS	ING HOME LAU	cation of Death REL RIN	Death CE GEORGE
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last 1 7 7 7 - 22 - 6003	birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	Birthplace (Stata or Foreign Country)
	ahow ahow	70	own or Location as hinston		10d. Inside City Limits
4	mar deem with the marylend of them 23e or 28e-f above closer must be notified at Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
4	ma 23a (Email b	317 DECATUR STREET,	V.W. 20011	U.S. 1	4.
	by i	3. Widowed 4 □ Divorced If Yas, Give Year or Datas:	Was Decedent of Hispanic Origin? (Spett Yes, specify Cuban, Mexican, Puerto □ Yas 2⊠ No Specify:	10-2-11 1211	American Indian, White, etc. BLAGK
in S	natural", of a feed by	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Giva kind of work done during most of work)	16b. Kind of Busin	
2121	DE CONTROL	Elementary/Secondary (0-12) College (1-4or 5+)	HOUSEKEEPER	4.5. Pos	office
Maryland	A COST	17. Father's Nama (First, Middle, Last)		(First, Middle, Maiden Sumama) IE GILCHR	ist
Mary	4 3 2 5	19a. Informent's Neme/Relationship (Type, Print) TULIA M BRICE) AUGUSTER	9b. Mailing Addrass (Street and Number or Rurs 1371 0010 N/NG STA WASHINGTON DC 2	Il Routa Number, City or Town, Sta CET, N. E. OO/ 9	ata, Zip Code)
ore	ages i end ant of Health mt: if Item 27 ry or other ti		of Disposition (Nama of tary, crematory or other place) MEMICLIAL (LEM. 8		y or Town, Stata
Balti	Department of Important: If I eny Injury or once.	21. Signature of Funerat Service Licensee	22. Nama and Address of Facility Hen. JAC, 4925, N. H. & Washinston, DC	y S. Was Wast	on + Song Co,
		23a. Part1. Entar tha disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of oving such as cardiac	20019 or respiratory errest	Approximete
	hysician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a. Hypo Ma	TREMFA.		Interval Between Onset and Death
ords, P.O. Box 68760,	attending physician and for use as the burel-transit clary/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	a consequence of): EMIPLEGIA a consequence of): EMISPHERE STO	BKE,	
8	d by the attend etached for us.	Part II. Other significant conditions contributing to death but not resulting	y in the underlying causa given in Pert I.	23b. Did tobacco use contri	bute to the cause of death?
S, P.O.	igned by the be detected by Physic		NSION.	1 Yea 2 No 3	Probably 40 Unknown
Records,	28 2			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
= F	s certificate hadirector, page			1 Yes 2 No	1 □ Yas 2 No
of Vital	certificate rector, pa	25. Was case referred to medical examiner?	26. Place of Deeth	(Check only one)	
of				me 5 Residence 6 Other (
Division	octor: After by the funer iffcation:	Natural 5 Pending (Month, Day Year) 2 Accident investigation	D. Tima of Injury at Work?	28d. Describe how injury occurred	
Divis	a star death. I Director: After a ed in by the funer Certification:	3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, building, atc. (Specify)	farm, street, factory, office	28f. Location (Street and Number of City or Town, State)	or Rural Routa Number,
I Honorday	Funer taly fill	29a. Certifier (Check only one) Certifying Physician; To the best of my knowled and manner stated.	ge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurr	and dua to the cause(s) and manne ed at the time, date and place, and	er as stated. I due to the cause(s)
Tothe	Withir To the comp	29b. Signature and title of certifier	29c. License number	29d. Data signed (A	
	(E)	Alidle Nayelli Mi.		t. 8_	7_1999
	0		1) (Type, Print) 56_FORT MEADE RO	AD LAUREL,	MD. 20724
	State Registrar	31. Data filed (Month, Day, Year) AUG 0 9 1999	5. Smit		

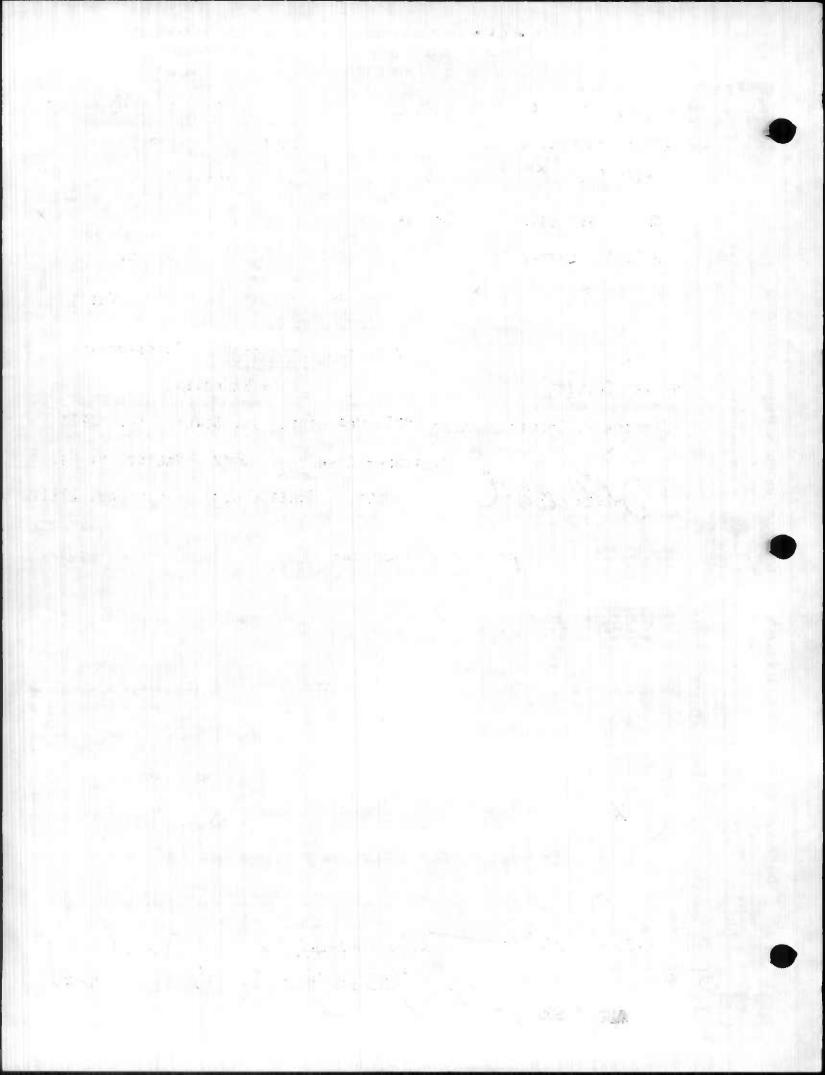
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	Certificate of Death	Reg. No.
Dharatalan	Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month Dey Yeer 3. Time of Deeth
Physician /Medical	ROBERT A. COOLICK	8 13 99 1120
Examiner		own, or Location of Deeth 4c. County of Deeth
	10213 McAllister RD. Ber	LIN WORCESTER
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under	
Director	177-12-0008 TM 2 F 76 Yrs. Months Deys Hours Usuel Residence of Decedent	10-8-22 PA.
72 hours effer death with the Maryland natural; or frems 23a or 28a-f show size Examiner must be notified at steel by Funeral Director	10e. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
r 28e-f show notified at	MD. WORCESTER BERLIN	1 ☐ Yes 2 No
rec rot	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?
23a or unit be	10213 McALLISTER RD. 21811	U.S.A.
r Herrs 23a or 28a-f a siner must be nothed Funeral Director	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orl If Yes, specify Cuben, Mexican	
ar, or he	Armed Forces? 1 Never Merried 2 Married 1 Yes 2 No If Yes, specify Cuben, Mexican 1 Yes 2 No If Yes, specify Cuben, Mexican 1 Yes 2 No Specify: Year or Deles:	
"netural",		16b. Kind of Business/Industry
1.4	(Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired)	of working
than "	Elementary/Secondery (0-12) College (1-4or 5+) BUILDING CONT	RACTOR CONSTRUCTION
marked other imatic avent, II	17. Fether's Neme (First, Middle, Last) 18. Mothe	er's Name (First, Middle, Meiden Sumeme)
Mental Hy arked oth atic avent	WALTER COOLICK MA	RY WALKOWIAK
end Mending and Me		er or Rural Route Number, City or Town, State, Zip Code)
0	10017 44 4	
item 27 other tr	20a Method of Disposition 20b. Place of Disposition (Name of	Dete 20c. Location - City or Town, State
0	1 ☐ Burlel 2 BCremetion 3 ☐ Removel from State cemetery, cremetory or other place)	19.14 C M-
ortant donate if	4 Donetion 5 Other (Specify) SALISBURY CREMATOR	
Oepa Impor	21. Signature of Funeral Service Licensee 22. Name and Address of Facility ULLRICH FUNE	RAL HOME BERLIN, Md. 21811
	23e. Pert. Efter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cerdiac or respiratory arrest, Approximate Intervel Between
hysician	Shock, of heart failure. List only one cause of sect line.	Onset and Deeth
Medical	Immediate Cause (Final disease or condition resulting In death) e. prostz te czwier	
xaminer	disease or condition resulting In death) e	84621
<u> </u>		
sician and bunal-transit	b	
Exa	if eny, leeding to immediate	
physician is the buna edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of):	
as the	resulting in death) Last	
nean signed by the attending physician and hould be deteched for use as the bunal-transitional by Physician/Medical Exami	d	
ed by the attending deteched for use a		
ched ched	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I	
detec detec		1 Yes 2 No 3 Probably 4 Unknow
signed to be det		24h Ware sutoney findings
page 2 should		24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
		of death?
page page		1 Yes 2 10 1 Yes 2 No
s certificate has t director, page 2 s	25. Was case referred to medical 26. Place	e of Death (Check only one)
I director.	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nu	ursing Home 5 Residence 8 Other (Specify)
	27. Manger of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury et Work?	28d. Describe how injury occurred
	Weturel 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □	No
r death actor: by the ificat	3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, factory, offica	28f. Location (Street and Number or Rural Route Number,
din din	4 Homlcide building, etc. (Specify)	City or Town, Stete)
within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date en end/or investigation, in my opinion, dee end menner stated.	nd plece, and due to the cause(s) end menner as stated. ath occurred et the time, date end pleca, end due to the cause(s)
Thin mple		29d. Date signed (Month, Dey, Year)
¥ 1 8	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	physici ++4428	13 HUG 13, 144
-	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	1. Q. 11 MY 7181
	hobert J. Durkin D.O., 4133 Healthwa	NUR, Derlin IIIDQIOI
State	31. Dete filed (Month, Day, Year) 23 Registrer's Signature	
Registrar	17 1999 South	

DHMH 16 Rev 6/95

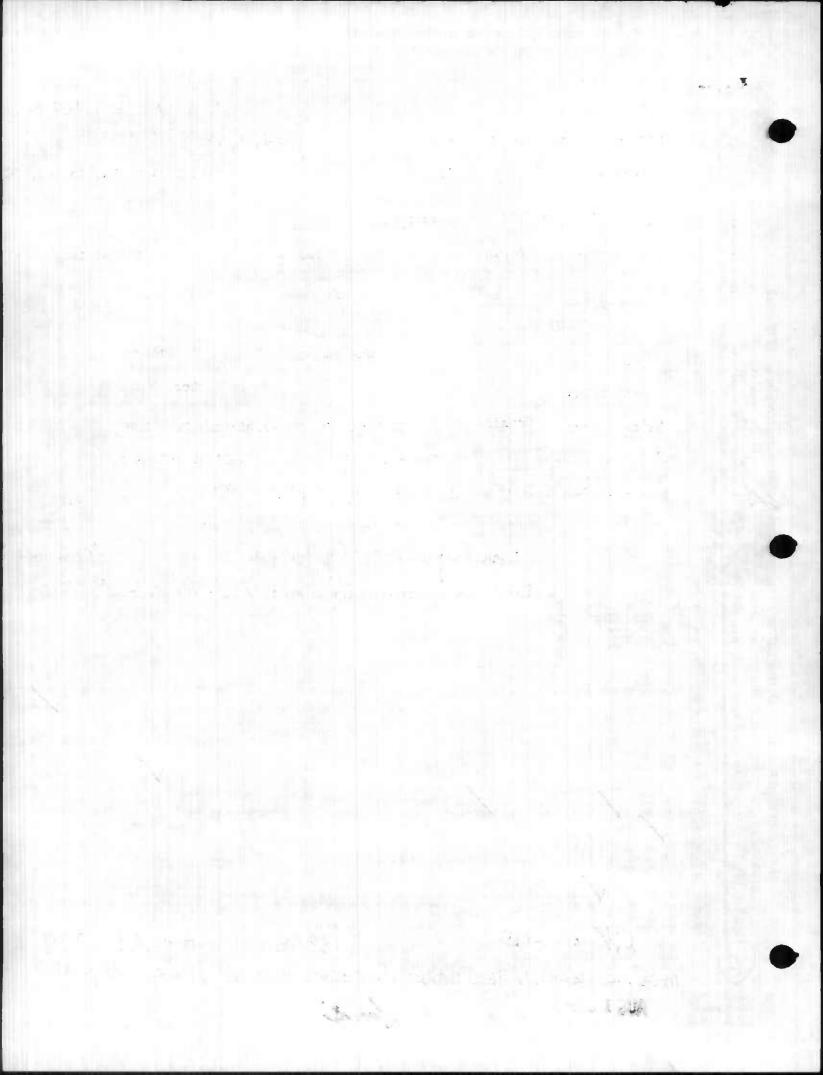


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State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Vear **Physician** Rezonne Duncan 3:01 pm 08 07 99 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park
If Under 24 Hrs. 8. Date
Hours Min. (Mon. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₺ № 2 □ F Months Days Yrs. 212-68-5521 41 Director 1957 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits show "natural", or items 23s or 28s-f shoredical Expression must be notified at 1XXYes 2 □ No Prince Georges Directo MD Adelphi 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 7957 15th Avenue # 206 20783 United States Funerai death Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours efter 1 Yes 20 No 1 Never Married 2 ☐ Married Raltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: P 3 ☐ Widowed 4 ☑ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) A permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the party fullury or other traumatic event, the page. Unknown Un- employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Janet Carter Robert Duncan 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cousin 2542 9th St. NW Washington Dc Disposition (Name of 20c. Debra James 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forrest Hills 8-11-99 Clinton. 21. Signature of Funerel Service Licensee 22. Name end Address of Facility DUDLEY FUNERAL HOME E.M. Dudler EDWARD M. DUDLEY 20712 3200 R.I. AVE., MT. RAINIER, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the bunal-trensit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequence of P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 98 use Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Vonknown á signed t Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deed page 2 hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director, 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2D No Certification: To 1 Yes 2 ER/Outpatient 3□ DOA this funerai 28a. Date of Injury (Month, Day Year) 27. Manyer of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After Netural 5 Pending efter deeth. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Mospital within 24 hours e To the Funeral C completely filled edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end tifle of certifier 1) 7610 CARROLL AVENUE, TAKOMA PARK, MARYLAND 30. Name and address of person who complete MoBARAIS KARIM,

State Registrar 82. Registrar's Signeture





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 27010

						Cei	rtificate	e of	Death			Reg. No.		
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П	Funerai		Social Sacurity Number 6. S.		a (In yrs. last		If Undar	1 Yaar Days	If Undar	24 Hrs. 8	Data of Birt (Month, Da	h v. Year)	9. Birth	piaca (Stata or Foreign ntry)
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	pus *		Usuai Residence of Decedent 10e. State 10b. County		10c. City, T	own or Lo	cation							
	sho	5		Cooner										10d. Insida City Limits
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Division of Vital Records,	frar d lirect in by	Certification:	3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicide datarmined	28a. Placa of Inju building, etc.	ry - At homa, (Specify)	, farm, stra	aat, factory,	offica		28	f. Location (S City or Tox		ber or Rur	al Routa Numbar,
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	(17)		30. Nema and eddress of person who c	omniated cause of do	ath (Itom 22	a) (Tuna	Drint)		, , ,				, , ,	1999 MD 21/22
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DHMH 16 Rev 6/95

Registrar

AUG 1 1 1999

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AMEND ITEM: #2 PER MD G776 10-25-99 Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death

Reg. No. 8-12-99 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** 130 PM 1999 Walter August Dorsev /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 9440 Buena Vista Ave. Prince Georges Seabrook If Under 1 Yaar 8. Deta of Birth (Month, Day, Year) March 10 1918 Maryland 5. Sociel Security Number 6. Sex. If Undar 24 Hrs. 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months Min 81 Yrs. 215-05-9506 Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits th and Mental hygiene.
7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Executer court be rectified at XXYas 2□No Directo Maryland Prince Georges Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter deeth with 1 and of Healet Hygiana.

Int. If tem 27 is marked other than anatural; or items 23a or 3 and 10 or other traumatic event, it was 9440 Buena Vista Ave. 20706 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 (X) Yas 2 □ No If Yes, Give Year or Detes: WWII 14. Raca - American Indian, Black, White, etc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Naver Marriad 2 ☐ Married 1 Yes 2 No Spacity: Specify: White Baltimore, Maryland 21215-0020 þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Dept. Of Navy Electronics Technician 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fathar's Neme (First, Middle, Last) Joseph Dziecuih Mary Bystryk 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Warren Dorsey (Son) 9440 Buena Vista Ave, Seabrook, MD 20706 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or othar place) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If I any Injury or Sacred Heart Of Mary Cem. 8/16/99 Baltimore, MD 21. Signeture of Funeral Service Licansee 22. Name and Address of Fecility
Rendon/Hale Funeral Home and 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart feiture. List only one cause on each line. MD 20706 Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Sepsis Months disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner that the deeth certificate be executed physician end s the burial-transit Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) attending pl signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert ii. 23b. Did tobacco uas contribute to the cause of death? 1 Yss 25 No 3 Probably 4 Unknown Respiratory Failure þ 24b. Were autopsy findings aveileble prior to 24a. Was en autopsy performed? Completed Congestive Heart Failure completion of cause of death? page 2 1 Yes 28 No 1 ☐ Yes 2 ☐ No certificata Multiple Decubitis Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner?

1 Yes 28 No Be 28. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) illed in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Holical mtaly f To the å 29d. Date signed (Month, Day, Year) 29b. Signatura and fifla of certifier 29c. License number D 01852 August 13, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore 4203 Queensbury Rd. Hyattsville, MD 20781 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State AUG 1 3 1999 Souls

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Registrar



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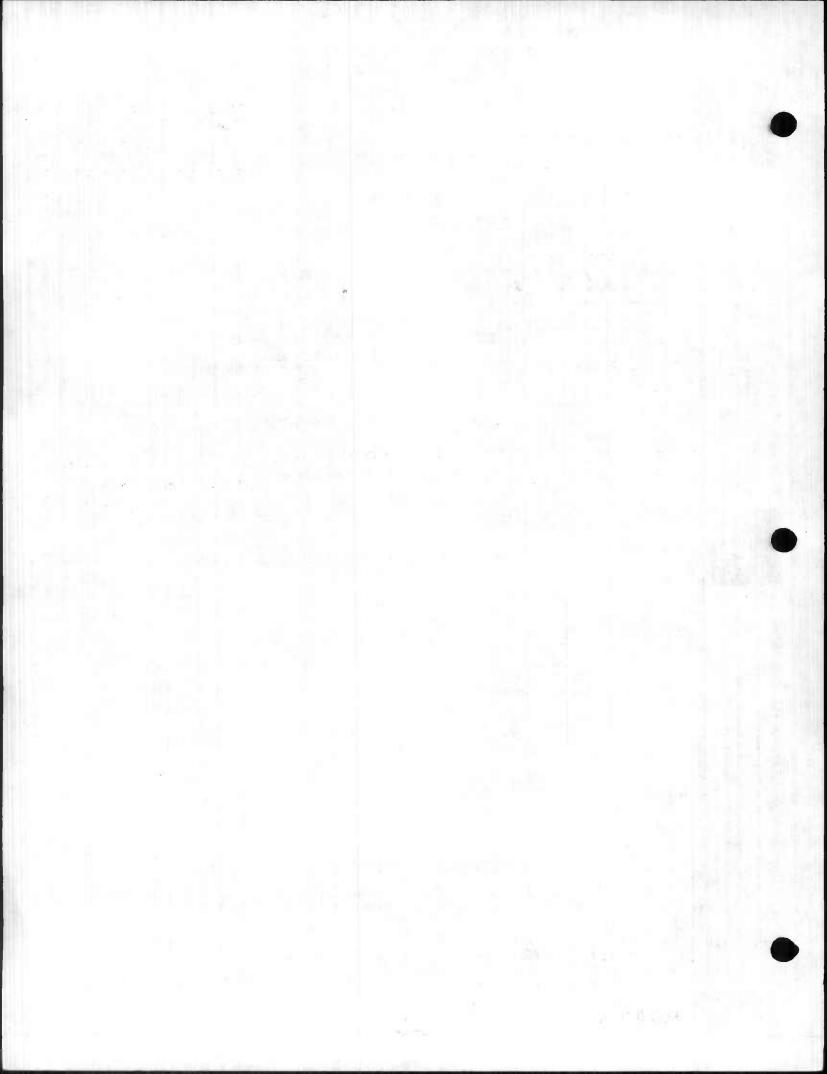
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Charles Richard Delaney 6, 1999 6:55 A.M Aug. /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 2706 Baldwin Lane Bowie Prince Georges If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (Steta or Foreign Country) **Funeral** 12 M 2□ F Months Days Hours 232-42-2929 Director West Virginia Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c City Town or Location 10d. Insida City Limits ahow 7 is marked other than "natural", or itema 23s or 28s-f sho traumatic event, the Medical Examinar mast be notified as 1 Yas 2 No Director Prince Georges Bowie Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706 Baldwin Lane 20715 US Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If hem 27 is marked other than "natural", or her any injury or other traumatic event, the Medican Emmin 1 Nevar Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 10 Vending routeman Food vending 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be George Samuel Delaney Rebecca Purkey 19a. tnformant's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary M. Delaney - Wife 2706 Baldwin Lane, Bowie, Md. 20715 20b. Plece of Disposition (Neme of commetery, crematory or other place)
Md. Veterans Cem. 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal Irom Stata 08-12-99 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Md. 21. Signatura of Funaral Service Licenses 22. Nama and Addrass of Facility Beall Funeral Home Robert G. Beall M00025 6512 N.W. Crain Hwy. Bowie, Md. 20715 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart lailure. List only one cause on each line. Approximate intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Luna month diseasa or condition rasulting in daath) Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Dua to (or as a consequence of) physician as the burial Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be detached Ves 20 No 3 Probably 4 Unknown Records. p 24b. Were autopsy lindings available prior to complation of cause of death? Completed 24e. Was an autopsy performed? 1 Yas 2 No 1 Yes 2 No certificata Division of Vital Be 25. Was casa ralarred to medical 26. Place of Death (Check only ona) Hospitat: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 2 this 28a. Data of Injury (Month, Day Year) 27. Megfar of Death Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. 1 Yas 2 No invastigation f or Attend after death Director: / 2 Accidant 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, larm, street, lectory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signatura and titla of conflier 29c. License number 29d. Data signed (Month, Day, Year) m 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print), Annapolis Med 21401 Peterson 600 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State AUG 0 9 1999 Registrar

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ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Godlove ALMOUST Margaret Noss 1999 9:55 PM /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mitchellville Prince Georges Collington Care Center If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Numb 146 09 2790 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) January 2 1905 Birthpiaca (Stata or Foreign Country) **Funeral** Months 1 □ M 2X F 94 Yrs Pernsylvania **Director** Usuel Residence of Decedant with the Marylend 10a. Stata 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be northed at MD Mitchellville Prince Georges 1 Yes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? 20721 United States 10450 Lottsford Road Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer of Depertment of Health and Mental Hyglene.

Important: If item 27 is marked other than "naturel", or iten eny Injury or other traumetic event, the Medical Exercises once. Black, Whita, atc 1 Nevar Married 2 Marriad Saltimore, Maryland 21215-0020 White 1 ☐ Yas 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamentery/Secondary (0-12) Color Laboratory Laboratory Assistant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Martzell Charles Lewis Noss Trene 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 9713 Manteo Ct. Ft. Washington Md. 20744 19a. Informant's Name/Ralationship (Type, Print) Son Terry F. Godlove 20b. Place of Disposition (Nama of cematary, cramatory or other piece. George 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 8/07/99 Washington DC Washington Univ. Med. Ctr. 4 Donation .5 ☐ Othar (Specify) 21. Signature of Junaral Servica Licenses 22. Name end Address of FecilityColumbia Mortuary Services PO Box 58007 Washington DC 20037 Part . Ener the Méase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** /Medical Immediata Causa (Finel diseesa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner certificate be executed physician end the burief-transit Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Ceusa (Disaasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) 88 980 ò the deteched Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by to should be detech 1 Yes 2 No 3 Probably 4 Hinknown ģ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has page 2 certificate 2 No 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific. funeral director, 25. Wes casa refarred to medical axaminar?

1 Yas 2 No Be 26. Pleca of Deeth (Check only ona) P Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Mannar of Deeth Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation Natural 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homleida 1) Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date end piece, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and menner stated. edical 29e. Certifian To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatura e 29d. Dete signed (Month, Day, Year) 29c. Licanse number 22 Name and addrass of person complated causa of daath (Item 23a) (Type, Print) 4 WICL.s 31. Date filad (Month, Day, Year) 2. Ragistrar's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene 0 0 9 7

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	pue *=	-		County		100	. City, Town or L	ocation						10d. inside City Limits
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State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** DORIS MAE ELLIS 14, Aug. 1999 12:50PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner I APLATA
If Under 24 Hrs.
Hours Min.

Min.
Dec. 26, 19 CIVISTA MEDICAL CENTER CHARLES If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 💢 F Deys 201-26-4365 Pennsylvania 1933 Director 65 Usuei Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County man be notified at 1 Yes 20XNo Directo Maryland Charles Waldorf 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 3664 Pine Cone Circle 20602 USA Funeral Pages 1 and 2 should be filed within 72 hours aftar death nent of Health and Mental Hygiene.
Int: If hear 27 Is marked other than "natural", or floms 23, my ordher traumatic event, as Medical Experient manny or other traumatic event, as Medical Experient manny or other traumatic event, as Medical Experient manny or other traumatic event, as Medical Experient manner. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4) Civorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Office Manager Medical 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Michael Toshok Helen Gesko 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Robert M. Ellis-Son 3664 Pine Cone Circle, Waldorf, MD 20602 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ★ remetion 3 ☐ Removel from State 8-15-99 Waldorf, MD Huntt Crematory 4 ☐ Donetion 5 ☐ Other (Specify) Huntt Funeral Home, Inc. 21 Signalure i Funeral Service Licenses John P. Knisley M01164 P. O. Box 156, Waldorf, MD 20604-0156 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** · COMPRESTIVE HEART FAILURE /Medicai Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician at a the burial-t Physician/Medical Due to (or es e consequence of) affending ph Nor use as t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No corfficate Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 100 funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Delaturel 2 Describent 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) after 4 Homicide ö 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the Wilhin 2 To the 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number Math D-28352 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Krishan M. Mathur, M.D. Cambridge Prof. Ctr. Suite 102 20602 Waldorf.

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State

Registrar

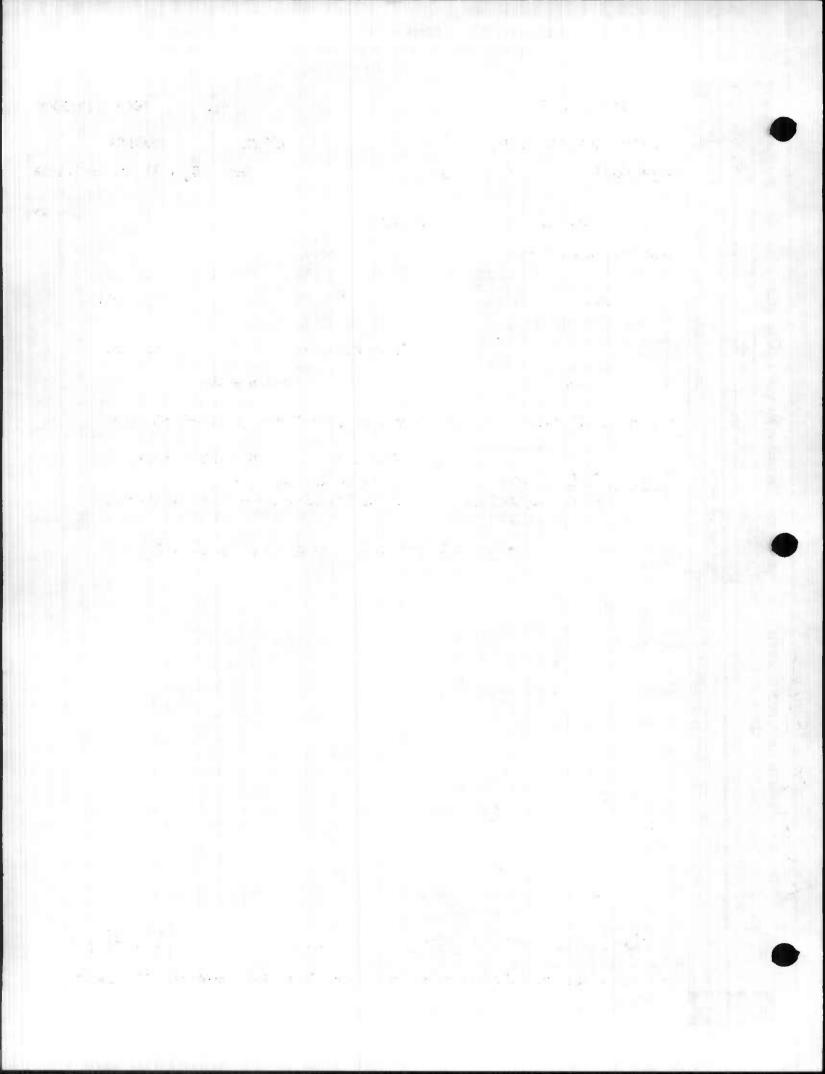
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32. Registrer's Signeture

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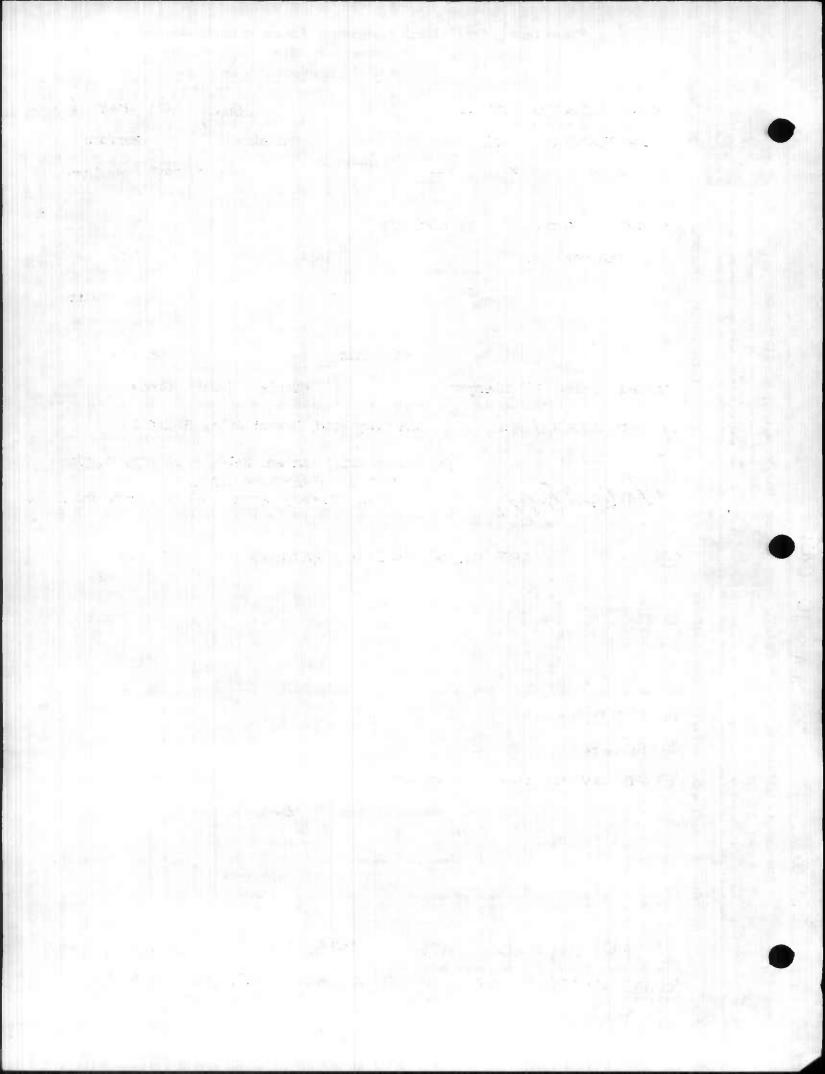
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State of Maryland / Department of Health and Mental Hygiene 🤾 🔾

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	5. S	oclei Security	Number	6. Sex		7. Age (In y	rs. last birthdey	/) If Under	r 1 Year Deys	if Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)	9	Birthplace	(State or Foreig
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Theodore Rosco Ervin 12:50 a.m. April 30 1999 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Residence: 724 Broad Street Perryville Cecil If Under 24 Hrs. 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Months Deys 229-30-1368 Yrs. Oct. 19,1931 West Virginia Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-1 sh .notified. 1 ☐ Yes 2 ☐ No Directo Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 724 Broad Street 21903 238 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, Whita, atc. 72 hours after 1 Never Merried 2 Merried 1 Yes 2 No
If Yes, Give Year or Dates: Saltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pier I Imports filled within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Professional Truck Driver Aberdeen, Maryland Eleven Years Pages 1 and 2 should be liled than of Health and Mental Hygient; If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Samuel R. Ervin Mary Shields 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (wife) 724 Broad Street, Perryville, Maryland Hazel B. Ervin important: If item 27 any injury or other tr. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete pQBurial 2 ☐ Cremetion 3 ☐ Removel from Stete West Nottingham Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Colora, Maryland 22, Nema end Address of Fecility me of Funeral S Lee A. Patterson & Son Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. 21903-0188 Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Vuscula-The law requires that the deeth certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown signed I Division of Vitai Records. þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? obstutive page 2 s 1 18 2 No 1 ☐ Yes 2 PNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifical completely filled in by the funeral director. 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 100 Medical Certification: To 1 Inpatient ER/Outpatient 3□ DOA 27. Manner of Death 28d. Describe how injury occurred 26b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29e. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, NPR 3 0 1999 32 Registrate Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hydiene

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Physician
/Medical
Examiner

Funeral Director

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Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int. If Hem 27 Is marked other than "natural", or he

21215-0020

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

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Physician /Medical **Examiner**

Attending Physician: The law requires that the death certificate be asscuted burial-transit and physician the 50 980 detact 2 been signed t page 2 certificate funeral director. this To the Heepital or Attending Phenims 24 hours after death.
To the Funeral Director: After the computery filled in by the funeral

1. Decedant's Nama (First, Middle, Last) Month Dav Year 1999 6,_ Eugene Noble Fleet, Jr 10:50A.M. AUGUST 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 100 M 2□ F 60 1939 Aug 6 Wash, 578-48-3901 Usual Rasidence of Deceda 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Washington 1 Yas 2 No D.C. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? St. N.E.# 1854 Kendall 202 20018 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1X Yas 2 □ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 ☐ Married SpecifyBlack 1 ☐ Yas 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Residence Manager Unknown 2yrs 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Eugene Noble Fleet Unknown 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Fleet Evans (daughter) 1708 Bradmoore Dr. Forestville, Md 20747 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) 8/13/99 Quantico, Va. Quantico National 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Austin Royster Funeral Home 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory affect, shock, or heart initiars. List only one ceuse on each line. 20011 Approximate Interval Batween Onset and Death Immediata Causa (Finel disaasa or condition rasulting in daath) LILL Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immadiata ceusa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown þ Completed 24b. Ware eutopsy lindings available prior to 24a. Wes en autopsy performed? completion of ceuse of death? 1 Yas 2 □ No Yes 2 No Be 25. Was casa relarred to medicel axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 💢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1XXYas 2□ No Certification: To 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 □ Yas 2 □ No 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) 4 - Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, daeth occurred at the tima, data and place, and due to tha cause(s) and mannar es stated. (Check only one) Medical Examiner: On the basis of axaminetion and/or invastigetion, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mannar stated.

State Registrar

THEVROLEY, KICY 31. Data liled (Month, Day, Year)
AUG 1 3 1999

29b. Signature and titla of certiliar

32. Registrar's Signatura

MUD

30. Name and address of person who compand ceusa of deeth (Item 23a) (Type, Print)

Obiles

29c. License number

O.C.M.E.

29d. Data signed (Month, Day, Year)

AUGUST 7,1999

111 Penn Street, Baltimore, Maryland 21201

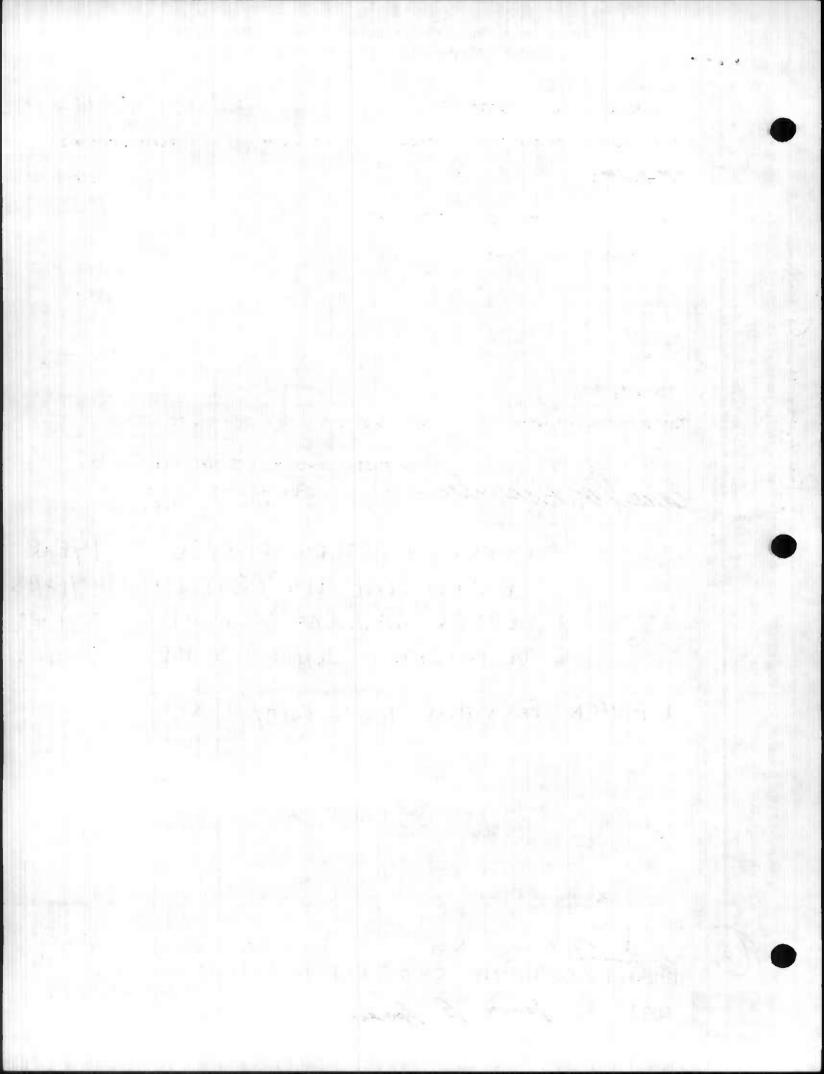
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 0620 P.M. RAYMOND L. **GREEN** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Mellennium Health Rehab. Ctr. Glen Burnie An

If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year) Anne Arundel If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1♥ M 2□ F Months Days 68 Director 579-38-6071 Camp Springs, MD 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits a notified at N☐ Yes 2☐ No MD Glen Burnie Director Anne arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 traumetic event, the Medical Examiner must be USA Barns 23s 7575 East Howard Road 21060 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married b 1 ☐ Yes 21 No Specify: **Black** ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Collaga (1-4or 5+) Elamantary/Secondary (0-12) 6 Cook Private Industry 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middla, Last) Be 1 and 2 should be Ida Lee James A. Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Cedar Heights, MD Department of Health important: If Itam 27 Lawrence Green/brother 6406 L Street Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Forest Hills Cemetery 8/13/1999 Clinton, MD no of Funda Service License 22. Name and Address of Fecility Tyrone J. Young Funeral Services 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or he in failure. List only one cause on each line. 20011 Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** RTENSION Examiner physician and the burial-fran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last the death certificate be exec Physician/Medical IMIOL 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. PROSTATIC 1 Yee 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? paga 2 s 1 ☐ Yes No No 1□Yes 2□No certificata Hospital or Attanding Physician: 25. Was cese raferrad to medical examiner? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Affar 1 Natural 5 Pending Investigation Injury after death. 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida 24 hours a Fumeral C 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. Medicai o the 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier. 29c. License number ITCHE HIGHWAY, BALTIMORE

State Registrar



State of Maryla

nd/	Department	of Health and	Mental	Hygiene
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Dav	vid Gray			Ce	ertificate of	Death	,	Reg. No.	9	27020
		1. Decedent's Neme (First, Mic	idle, Last)				2. Date of De	eth		3. Time of Death
	Physician	Dav	id Eugene	Gray			Augus	Day	Year 199	1:14 A.M.
	/Medical Examiner	4s Fecility Name (If not institut	tion, give street and number	7)		4b. City, Town, or L				11:14 A.M.
	Examine	2140 Bell Tr	ee Lane			Waldorf		Charl	29	
	Funeral	5. Social Security Number	6. Sex 7. A	lge (In yrs. last birthday	ff Under 1 Year	If Under 24 Hrs.	8. Dete of Bir (Month, De			lece (Stete or Foreign
ш	Director	212-26-2224	1∭ M 2□ F	44 Yrs.	Months Days	Hours Min.	Nov. 23	1954	Washi	ngton, D.C.
	9	Usual Residence of Decedent								
	and	10a. State 10b. Cour	*	10c. City, Town or I					1	Od. Inside City Limits
	the Ma 28e-f s potified	Maryland Cha	arles	Wald	ori					1 Yes 2 No
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	72 hours after death with the Maryland natural; or laens 23s or 25s-f show dical Examiner must be notified at wheel his Furnamal Director		e Lane		20601			U.S.A.		
	fler death viller as 23 inner must	11. Merital Status	12. Was Deceden Armed Forces		. Wes Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Bled	e - Americ ck, White,	
20	ample of F		If Yes, Give		1□ Yes 2Ĭ No				Whit	
Maryland 21215-0020	araf. a		300							
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	Tast Page	Robert F. Gray	Jr./Brothe	er 803 20b. Place of Dist	Kenyon Av	re. Waldor	f, MD 2	20c. Location -	City or Te	um Clata
Baltimore,	10 H 0	1 Burial 2 ☐ Cremetio	n 3 Removel from State	cemetery, cn	emetory or other pla	Gardens 8				
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	-	23a Part1. Enter the disease, shock, or heart failure. L	or complications that cause at only one cause on each	ed the death. Do not ex line.	nter the mode of dy	ing, such as cardiac	or respiratory a	rrest.		Approximate Interval Between
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	/Medical Examiner	tmmediate Cause (Final disease or condition	. Sh	nus To	11/0	sund	07	7 /6	150	>
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	2 = 2 0	ane)	and manner s	steted.			red or the time,			
	To T	29b. Signature and title of certif	ier	11		ise number		29d. Date signe	d (Month,	Day, Year)
	(1)	LPe	flane	J. M. T) (O.C.M.E.		August	04, 1	.999
	(6)	30. Name and address of perso	n who completed cause of	death (Item 23a) (Type	, Print)					
		JOSED	n rest	aner 1	11 Penn S	Street, Ba	altimore	Maryl	and 2	21201

State Registrar

31. Date filed (Month, Day (Year) AUG 0 9 1999 restance

					State	of Mai	ryland /		ment of I ficate of			ental Hy	giene 🤰 🗎 Reg. No.	3 2	1021
	Physicis	_	1. Decedent's Name	e (First, Middle	, Last)							2. Date of De	eath Day	Year	3. Time of Death
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Box 68760,	licate be physicia s the bur	edical	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting In death) I		d	lyy,	ue to (gras a	usi	on	tu	0.				
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	Hospi 24 hou Funer tely fill	edicai	29a. Certifier (Check only one)	1 Certifyin 2 Medicai	g Phyelcian: To the Examiner: On the and me	ne best of basis of e	xamination a	ge, death oc and/or invest	curred et the ti igation, in my	ime, date en opinion, des	nd place, ea ath occurre	nd due to the d at the time	ceuse(s) and m , date and place,	anner es a and due t	stated. the cause(s)
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	([]		30. Name and addr	ess of person	who completed ca	use of dea	ath (item 23a	(Type, Prin	IOCDTTA	T. TJA	сн п	C 2001	7	1100-2	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 27022

		Certificate o	f Death	Reg. N		L. I V L. L.
	Decedent's Neme (First, Middle, Last)			2. Dete of Deeth Month	Dey Year	3. Time of Death
Physician /Medical	Leroy Gaskin			August	5 1999	14:20
Examiner	4e Facility Neme (If not institution, give street end number)		4b. City, Town, or Loc	ation of Death	tc. County of Deeth	
	Prince George's Hospital		Cheverly		Prince (George's
Funeral Director	231-18-7717 X□M 2□F	yrs. last birthday) If Under 1 Ye 75 Yrs. Months Dey	e Houre Min	B. Date of Birth (Month, Dey, Yea June 5, 1	9. Birth Cou Vir	plece (State or Foreig ntry) ginia
D .	Usuel Residenca of Decedent 10a. Stete 10b. County 10c	: City, Town or Location				10d. Inside City Limits
short short						1 DYes 2 □ No
Pect ect	Maryland Prince George's	North Engle		10- 1	Citizen of What Cou	-1-0
ifter death with the Maritems 23s or 28s-fs	1601 Woodhill Court		0785		United S	States
	11. Maritel Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever Arquet Forces? 1 ☑ Wes 2 □ No If Yes, Give Yeer or Detes:	1□ Yes 2ŪŴ			14. Race - Ameri Bieck, White Specify: B	
be filed within 72 houseled Hygiene. I other than "nature event, the Medical Be Completed	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usuel Occ (Give kind of work dor life. DO NOT use ret	cupetion ne during most of working	16b.	Kind of Business/Ir	ndustry
ithin nan	Elementery/Secondary (0-12) Coilege (1-4or 5+)					
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Be went H	17. Fether's Neme (First, Middle, Last)		18. Mother's Neme		en Sumame)	
Ment Ment Ment Ment Ment Ment Ment Ment	Henry Gaston			Edwards		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "naturel;, any injury or other traumatic event, the Medical Engage. To Be Completed by	19e. Informent's Neme/Reletionship (Type, Print) Nina L. Gaskin - Wife	19b. Mailing Address (Street 1601 Woodhi	11 Ct., Nor			20785
semit. Pages 1 and 2 should be file beginnent of Health end Mentel Hymportant: if item 27 is marked other ny injury or other traumetic event, and. To Be C		 Place of Disposition (Name of cametery, cremetory or other p 	o/eca)	Dete 20c.	Location - City or T	own, Stete
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Depentir. Imports any inju	21. Signeture of Funeral Service Licentee	22. Name end Add	S		neral Hom	
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_	23a. Perf. Enter the disease, or complications that caused the shock, or heert failure. List only one ceuse on each line.	deeth. Do not enter the mode of o	lying, such es cardiec or	respiretory errest,		Approximete Intervel Between
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n end	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or es e consequenca or).				
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s cert direct	examiner? Hospital:	2 □ ER/Outpatient 3 □ DOA	Other:		8 Other (Spec	ifu)
Attending Physician: The law requires that the death certificate be executed at deeth. ector: After this certificate has been signed by the ettending physician end by the funeral director, page 2 should be detached for use as the burial-transitification: To Be Completed by Physician/Medical Examil	27. Menner of Deeth 1 ☐ Neture	28b. Time of 28c. In V		8d. Describe how in		
To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	2 Could not be	At home, farm, street, factory, office	- 115- / / / / / / / / / / / / / / / / / / /	8f. Location (Street City or Town, St	and Number or Ru lete)	ral Route Number,
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(15)	30. Name and address of person who completes chuse of death	(Item 23e) (Type, Print)		7	1 14	,
(0)	3001 HOSP. AN DR. C	hevery, M	20785	DR.C	Ervin	/
State	31. Dete filed (Month, Dey, Year) ALIC 0 9 1999	Signeture				
Registrar	AUG 0 9 1999	M. MORKE				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) CORRINE GERTRUDE HAMILTON August 1999 6 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

3. Time of Death

4:05 PM

Laurel Md 20725- 0385

Physician /Medical Examiner **Funeral** Director Directo Examiner must be o Baltimore, Maryland 21215-0020 "natural", or þ the Medical filed within Hygiene. marked other Commit. Pages 1 and 2 should be filed.

Spoatment of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event once. Physician /Medical Examiner

Prince George's St Thomas More Nursing Home Hyattsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F Months Days Hours Min Yrs. Jan. 26, 1919 Washington, D.C 074-16-3192 80 Usuel Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Sisalbed Drive 20743 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No ff Yes, Give Year or Dates: 14. Race - American Indien. 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: **Black** 3 Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupefion (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Technician Private 11th 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Julius Brown Mary Brown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Delores Holmes/Daughter 6806 Sisalbed Drive, Capitol Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 08/12 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State S ☐ Other (Specify) Lincoln Memorial Cemetery 4 Donation 1999 Suitland, Maryland J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 Landover Road, Landover, Maryland 20785 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Ceuse (Finel diseese or condition resulting In death) Thrombo Embo L; sm Pulmonary 2 Hrs and Per: pheral Vasedon 2 yrs Examiner De+p Vein attending physician and for usa es the burial-transit The law requires that the deeth cartificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Last Dependent Diabetes Mellitus 204 P.O. Box 68760. Insulin Physician/Medical Due to (or es a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypentensin signed t Division of Vital Records, by 24b. Were autopsy findings evailable prior to should should Completed 24e. Was an autopsy periormed? completion of cause of death? director, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No of or Attending Physician: effer death. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes Director: A 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and fittle of certifier 29c. License number August 11, 1999 completed cause of death (Item 23a) (Type, Print)

nes MD Po Box 385 30. Name and address of person

DHMH 16 Rev 6/95

State Registrar Gary

31. Dete filed (Month, Dey, Year)

W Jones

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Dorothy Hall August 9, 1999 10:30 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1202 Stratwood Avenue Prince Georges Oxon Hill 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Funeral Months Days Hours 1 M ACF 220-07-8128 Yrs. 81 Director May 4, 1918 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiena.
Int: if Itam 27 is marked other than "natural", or items 23s or 28s-f show any or other treumstic event, the Madesil Examinar must be notified at 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Prince Georges Directo Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1202 Stratwood Ave. 20745 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X⊠ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: þ Specity: White 3 Ø Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) National Park Service Data Processor Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surneme) George Theodore Shumate Nora Mae Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Gwendolyn May Cornell/Daughter 6902 Furness Ave., Oxon Hill, MD 20745 20b. Place of Disposition (Neme of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 12OXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or page. Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/13/1999 Brentwood, MD 22. Nama and Address of Facility
George P. Kalas Funeral Home, P.A.
6160 Oxon Hill Rd., Oxon Hill, MD 20745 21. Signature of Funeral Service Licensee (ala) ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, the failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burie Box 68760, Physician/Medical Due to (or as a consequence of): been signed by the attending p should be detached for use as: P.O. of conditions contributing to death but not resulting in the underlying causa given in Part 1. 23b. Did tobacco use contributs to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformed? certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital after death.

Director: After this certifica 25. Was case referred to medical examiner? 88 26. Place of Death (Check only ona) 1□Yes 712 No Other: 4 ☐ Nursing Homa 5 🔀 Rasidenca 6 ☐ Othar (Specify) Cartification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending OCMatural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital of Within 24 hours a To the Funeral D 113 Certifying Physicians To the best of my knowledge, death occurred at the time, deta and place, and due to the ceusa(s) and manner as stated.
2 Interface Communication and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29s. Certifier 29b. Signature and title

Registrar

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AUG 1 1 1999

ed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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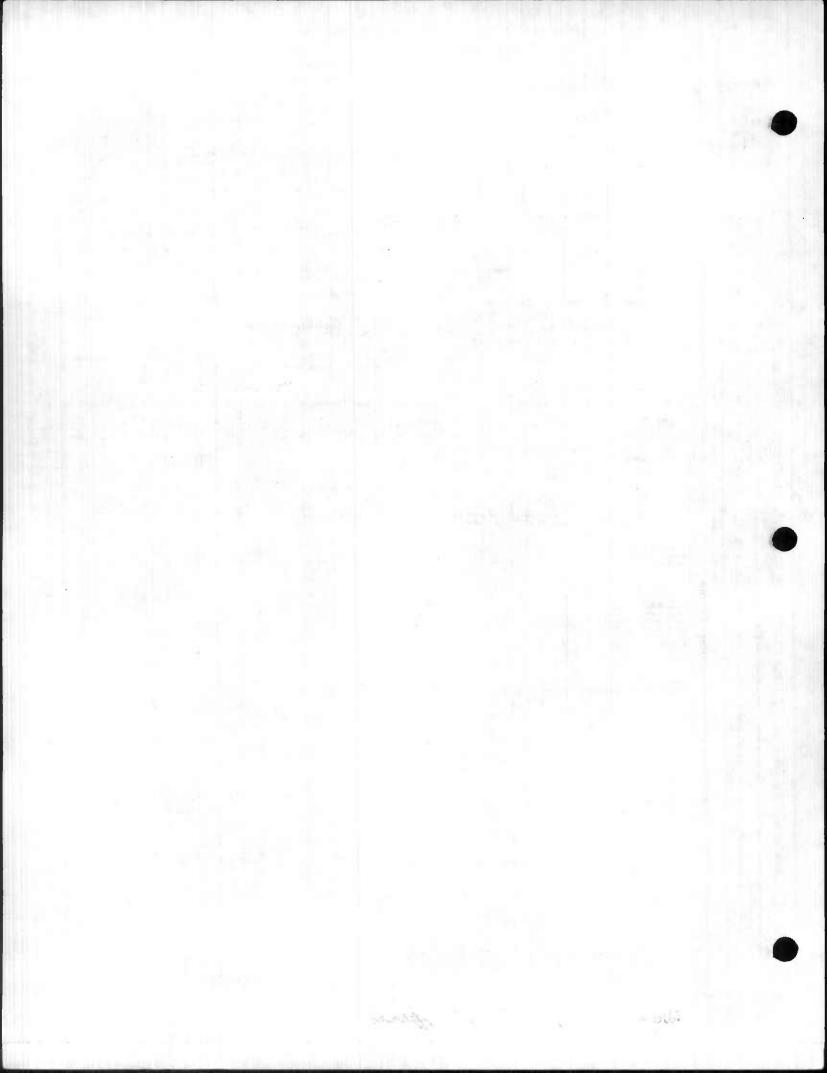
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tims of Deeth Dsy Month **Physician** JAMES L. HUTCHINSON AUGUST 10,1999 4:30am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5804 ANNAPOLIS RD #214 C BLADENSBURG PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours 218-56-7819 48 Director APRIL 26,1951 WASHINGTON DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No r. must be notified Director MD PRINCE GEORGES BLADENSBURG ŝ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hems 23s or 5804 ANNAPOLIS RD #214 C 20710 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status r than "natural", or han the Medical Examinar filed within 72 hours after Hygiene. Wher then "netural", or its 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK ğ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 COMPUTER TECH PRIVATE permit. Pages 1 and 2 ahould be liter. Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) e LEROY C. HUTCHINSON AGNES CAMPBELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5804 ANNAPOLIS RD APT# 214C BLADENSBURG, MD 20710 AGNES B. HUTCHINSON/ MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 8-16-99 SUITLAND, MD 22. Name and Address of Facility
ALEXNADER S. POPE FUNERAL HOME 21 Signature of Fluneral Service Lice 2617 PENN. AVE S.E. WASHINGTON DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final HEPATIC FAILURE disease or condition resulting in death) 1 MONTH Examiner Due to (or es a consequence of): CIRRHOSIS YEARS burdal-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events regulting in destrict.) Due to (or es s consequence of): and physician a the burial Box 68760. CHRONIC UNKNOWN ACTIVE HEPATITUS edicai that initiated events resulting in death) Last Due to (or es e consequence of) Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings sysilable prior to completion of cause of death? Completed 24a. Was an sutopsy performed? ps0e2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) 2 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 2 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 曹 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? Attac Athending 1 Natural 5 Pending investigation 78 Hospital or Alth. 74 hours after death. 19 by the 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide A 24 hours Districted by 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as ststed.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) To the To To The The To The The To Th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dsy, Year) Umareleade MD 25618 AUGUST 11,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEWIS W. MARSHALL, M.D. 1160 VARNUM ST. N.E. WASHINGTON DC 20017 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 1999

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Registrar

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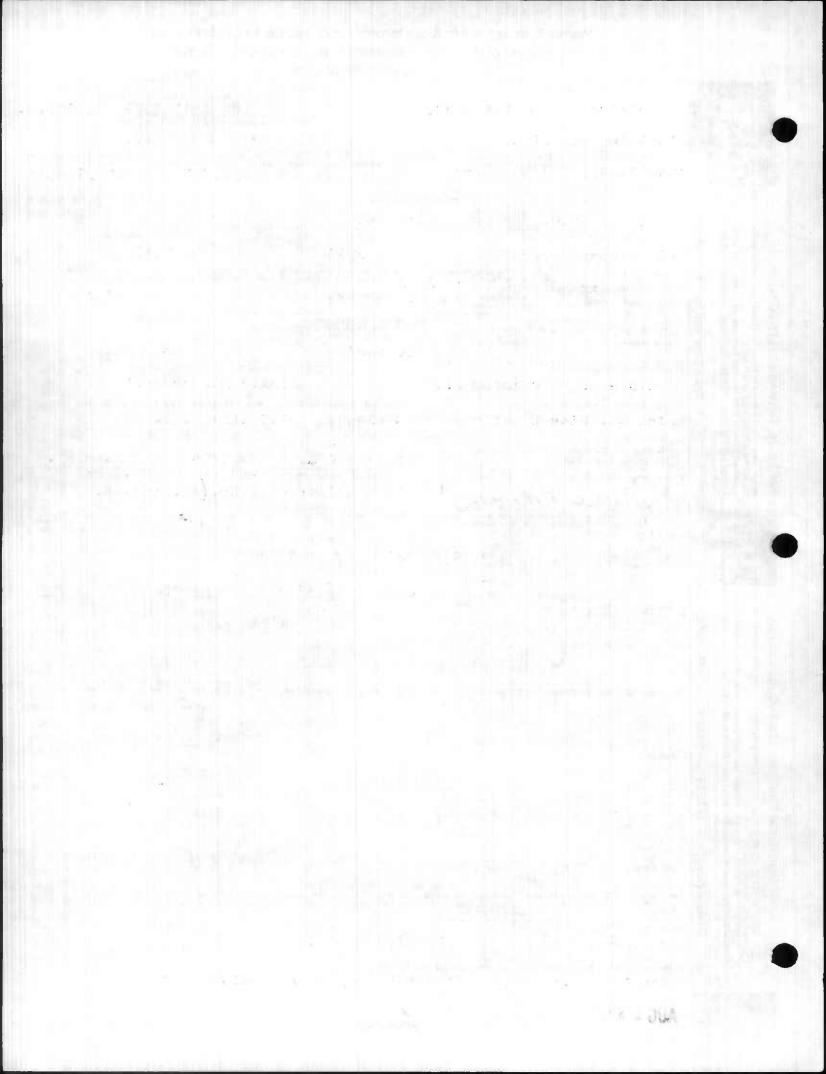


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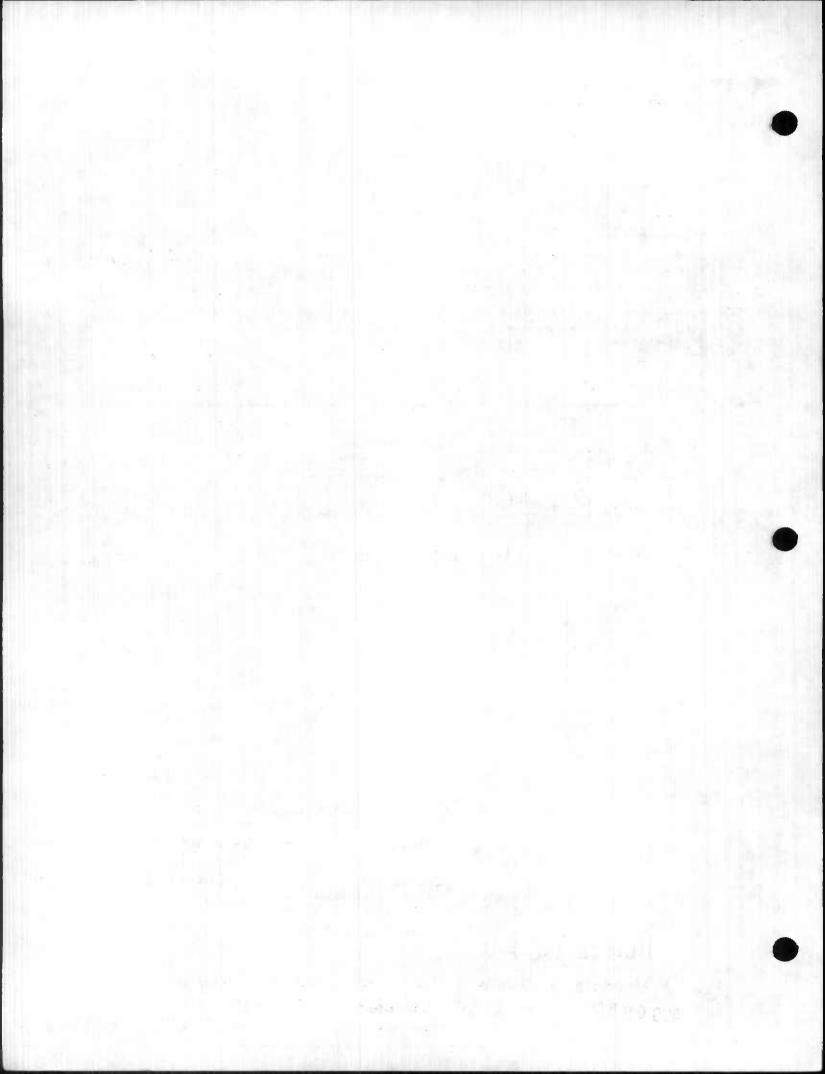
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State of Maryland / Department of Health and Mental Hygiene 27027

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	Funeral Director		Sex 7. Age (In yrs 11		If Under 1 Yaar Months Days			th. Year) 0,1953	9. Birthpla Country	ace (State or Foreign
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Maryland 21215-0020	72 hours after death vinature!; or items 23 dical Examiner must	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in It Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	J,S. 13. Wa	as Decedent of F ras, specify Cub			Blac	ck, Whila, at	Resident nindien, tc. panic
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a	2 sho and is me	19a. Informant's Name/Relationship		19b. Mailing	Addrass (Street	and Number or F	Rural Route Numb	er, City or Town,	Stata, Zip C	Code)
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		30. Nama and address of person who HDMPOMTD }	completed causa of death (Ite			Baltimo	re, Mary	land 212	201	
	State	31. Data filed (Month, Day, Year)	32. Registrar's agn	atura docu	the state of the s					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician Charles Hawkins 1999 L. August 6:20AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Southern Maryland Prince George's Clinton 8. Dete of Birth (Month, Day, Year) Aug. 31, 1919 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 GM 2□ F Months Hours 579-10-9265 79 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits The Maryta. 1 Yes 2 No Director 288-7 Maryland Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ð 5502 Walker Mill Road 20743 23a United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (≜Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after instrict Health and Mental Hydjaco.
Int. If them 27 is marked other than "natural", or lites iny or other traumels event, the Medical Exemptine iny or other traumels event, the Medical Exemptine 1 Never Married 2 Married 21215-0020 Black 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12th College (1-4or 5+) Truck Driver Private Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Charles Hawkins Gertrude Hall 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informent's Neme/Ralationship (Type, Print) Lavon R. Hawkins - Son 5502 Walker Mill Road, Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or 8/12/99 Maryland Veterans Cem. Cheltenham, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final chamic renal disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner upertousion To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlant-insnaft Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initialed events resulting In death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Fx Femur. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa raferred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46478 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Suratts Red # 307. Clinton, mp 20735 Suresh A. Patelino 7501 31. Date filed (Month, Day, Year) 62. Registrar's Signature State AUG 1 0 1999

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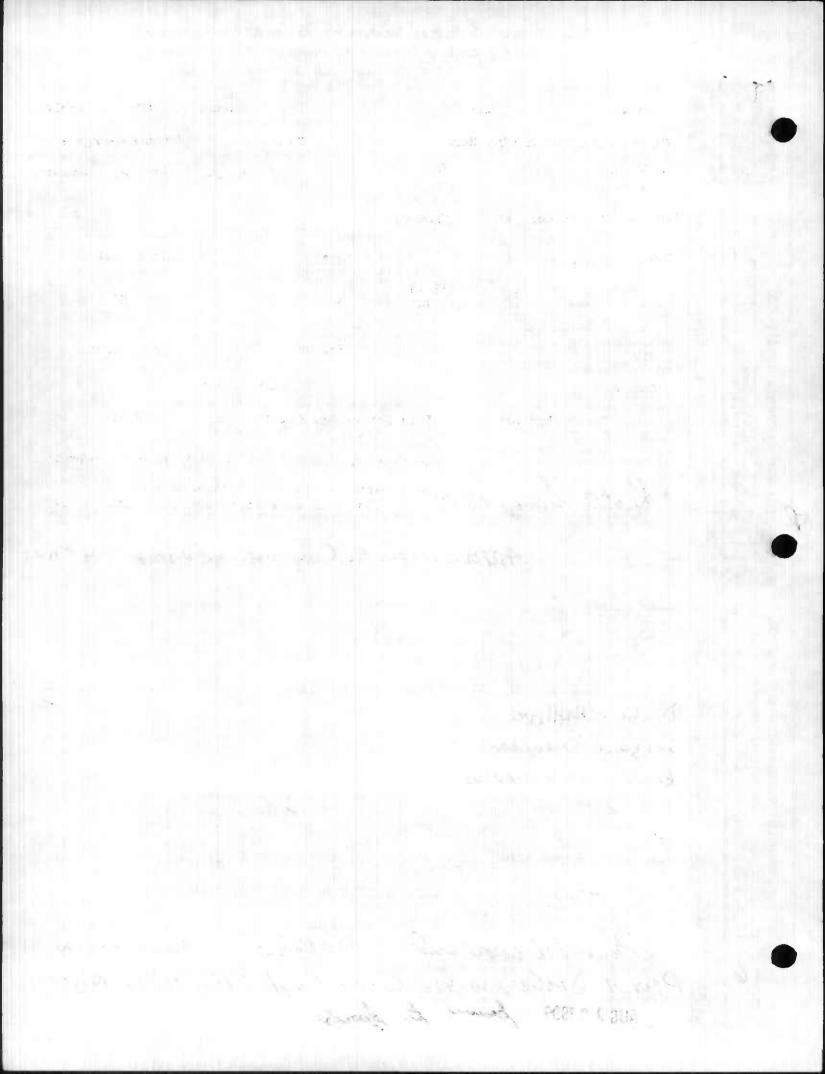
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State of Maryland / Department of Health and Mental Hygiene

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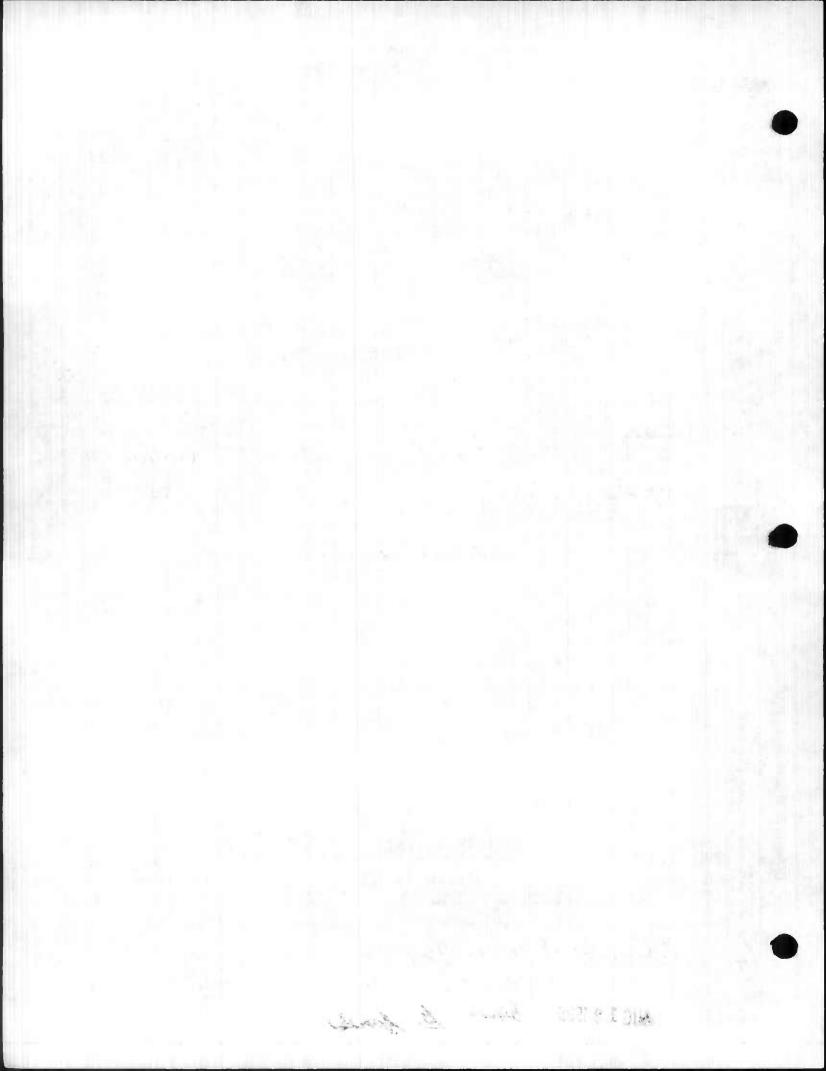
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State Registrar

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32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death AUGUST 10,1999 **Physician** 9:15pm DENTON /Medical 4a Facility Name (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGES 7604 JAYWICK AVE FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Aga (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Deys Months Hours 1 XM 2 ☐ F Yrs. 61 Director 219-32-3864 SEPT. 4,1937 BALTIMORE, MD Usuel Residence of Decedent 15 1/14 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notified at X☐ Yes 2☐ No Directo PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Nerva 23a 7604 JAYWICK AVE UNITED STATES Funeral 20747 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status hours after XYes 2 No Yes, Give 1 Never Merried 2 Merried natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Year or Detes: Completed permit. Pages 1 and 2 ahould be lifed within 72 is Oopstmort of Health and Mental Hyglere. Importanti if Item 27 is merked other than "natu any Injury or other traumatic event, the Medical Stics. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ELECTRIC ENGINEER PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be DENTON BRUSHAW JOHNS To MARY CLARK 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) MICHELLE JOHNS / DAUGHTER 7604 JAYWICK AVE, FORT WASHINGTON, MD 20744 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) STATE VETERANS CEMETERY 8-17-99 CHELTENHAM, MD 22. Neme end Address of Facility Fall Service/Licens ALEXANDER S. POPE FUNERAL HOME 23a. Pert1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finet disease or condition resulting in death) /Medical Pancreatic 9 months **Examiner** Due to (or as e consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disees or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. physician s the burle Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably W Unknown þ Records. 5 8 page 2 should Be Completed 24b. Were autopsy findings aveilable prior to 24a. Wes an eutopsy performed? completion of cause of death? 20 No 2 No 1 Yes 1 Yes certificata of Vital Hospital or Attending Physician: 25. Was cese referred to medicel 26. Place of Death (Check only one) axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affer Division Injury Naturel 5 Panding Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 \ Homicide • Funeral 29e. Certifier 🗸 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. completely Madical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Vithin 2 and menner stated. 29b Signature and title of ourth 29c. License number 29d. Dete algned (Month, Day, Year) 08-11+99 MD 057546 - L

Registrar

State

ROBERT DONEGAN M.D. 1050 W. PERIMETER RD, ANDREWS AFB, MD 20762 31. Date filed (Month, Dey, Year) AUG 1 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

P261 6 1 6118

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth

Physician /Medical Examiner

Funeral

Director death with the Meryland 10e Stete 7 is marked other than "naturel", or items 23s or 28s-f show traumatic avent, the Medical Examiner must be notified at Director Mary land Funeral Pages 1 and 2 should be filed within 72 hours effer of order of Health and Mentel by lygiene.
Int: If flem 27 is marked other than "natural", or fles into or other traumatic avent, the Medical Examinating Baltimore, Maryland 21215-0020 h Be Department of Important: If any Injury o **Physician** /Medicai Examiner Examiner law requires that the death certificate be axecuted physician and sthe burial-trans P.O. Box 68760, Physician/Medical signed by Records, by Completed peen certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be 2 Certification: 1 & Natural 3 Sulcida 29a. Cartifier Medical completely (Check only one) within 2 29b. Signeture and title of certifier

1. Decedent's Name (First, Middle, Last) 3. Time of Death August 09 1999 3:30 AM REGINA **JACKSON** 4e Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince George's Golden Oaks Nursing Home Laurel 5. Social Security Number Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) 11 M 2□ F 98 213-26-1442 March 23, 1901 Maryland Usual Residence of Deceden 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Nes 2 No Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1921 Vermont Avenue 20785 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 D Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest greda completed) Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) (Unknown) Shipley Kate Shipley 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Niece Marie Watkins/Great-great-grand 1921 Vermont Avenue, Landover, Maryland 20785 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08/11 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, Maryland 4 Donetion 5 Other (Specify) 1999 21. Signeture of Funeral Service Licensee J. B. JENKINS FUNERAL HOME Perce 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximata fntervat Between Onsef and Death Immediate Cause (Finel disease or condition resulting in death) PULMONARY CONGESTIVE HEART FAILURE

Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediata cause. Entar Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest CARDIOMYOPATHY HYPERTENSIVE

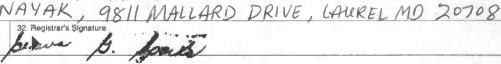
Due to (or as a consequence of): SENILITY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 12 Unknown CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 1 TYPS 2 TONO 1 Yes 2 No 25. Wes cese referred to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Panding investigation 1 Yas 2 Accidant 6 Could not be determined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, date and place, and dua to the ceusa(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Dey, Year) AUG 1 1 1999

LIPISHREE

30. Nama and address of persen who complated causa of daeth (Item 23a) (Type, Print)

NAYAK

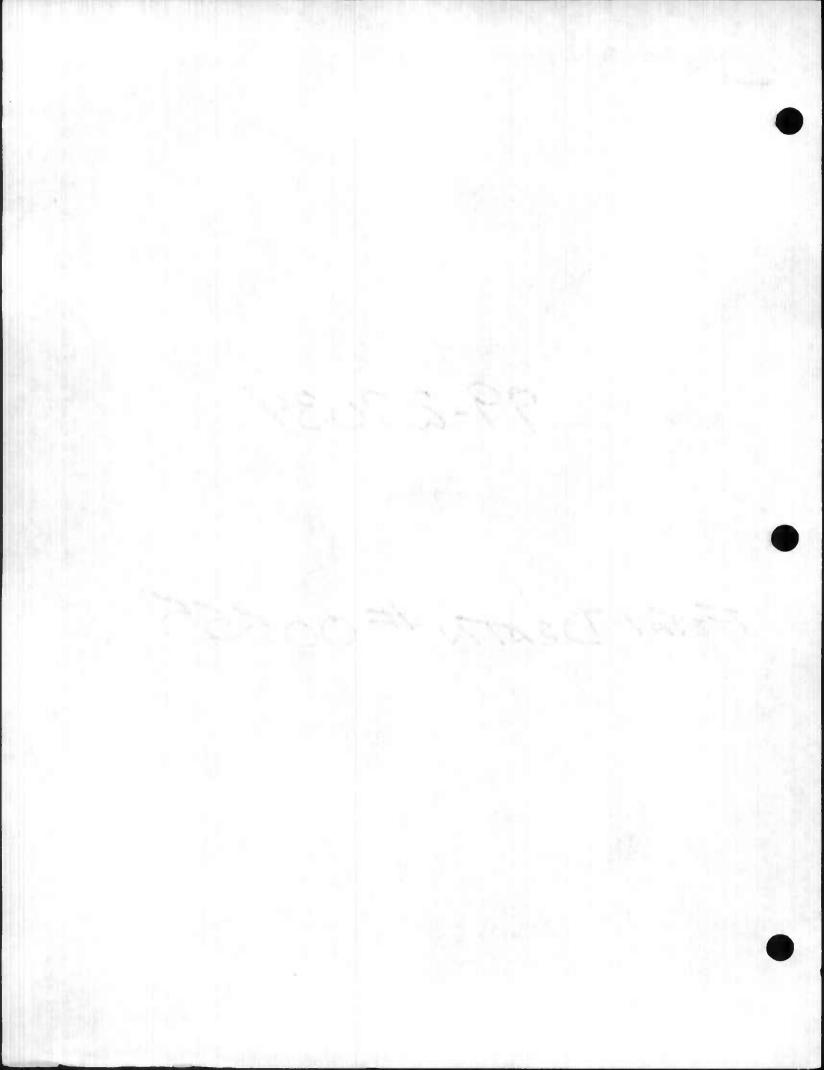


DHMH 16 Rev 6/95

VOID
CERTIFICATE # 29-27034

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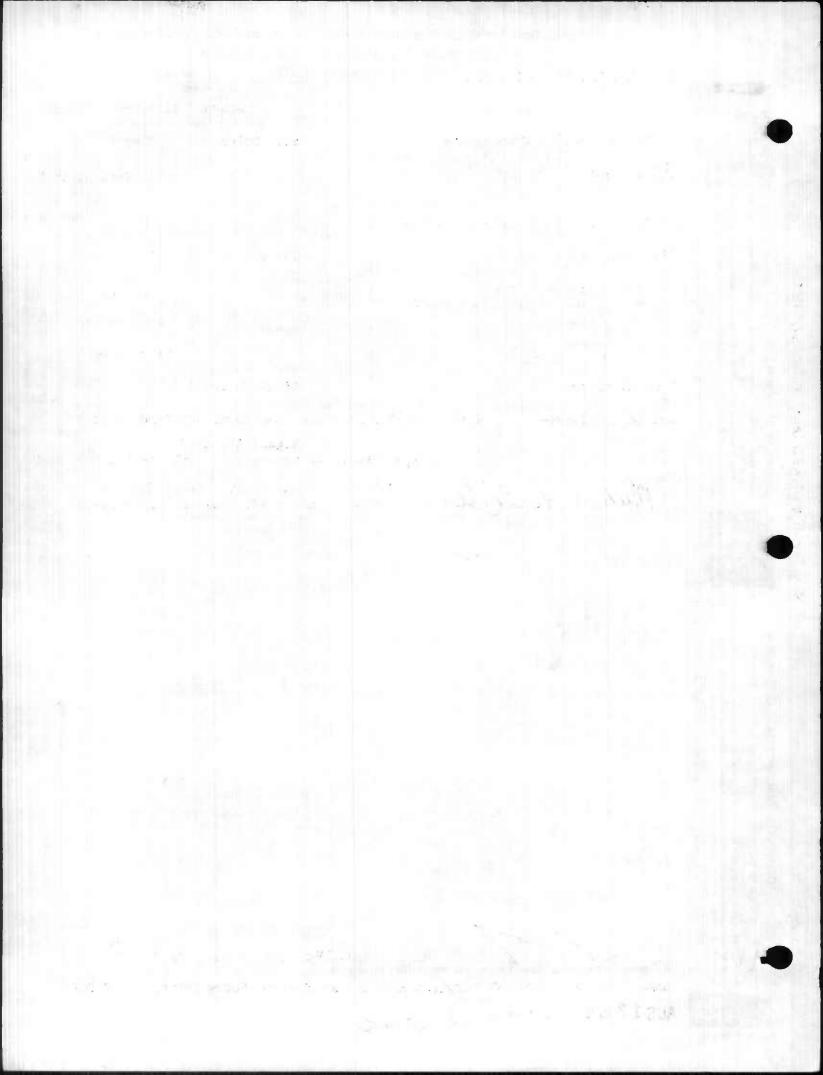
CERTIFICATE # FETAL DEATIN # 00555



		AMEND#5 PER. F.H. G774	State of Ma		partme ertifica				giene 9	2	7035
	Dhuniaian	1. Decedent's Name (First, Middle, L.						2. Date of De	ath Day	Yaar	3. Time of Death
	Physician /Medical	James N.	Klaassen					August	11 19	99	7:25PM
	Examiner	4a Facility Name (If not Institution, gr VA Maryland Healt		·am		4		or Location of Deat			
		5 Social Security Number 6		.em (In yrs. last birthdi	av) If Und	er 1 Year	Perry If Undar 24 H			Cil 9 Birthols	ace (State or Foreign
	Funeral Director	213-40-6455	HCXM 2□F	57 Yrs	Months	Days	Hours M	in. B. Date of Bir (Month, De			ace (State or Foreign ry) ngton D.C.
	9	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			100111			d. Inside City Limits
	l'ahon	2007075	George's		Location					10	XXYes 2 □ No
	or 28s-1s be noutled	Maryland Prince	George S	Bowie	10f. Z	ip Code			10g. Citizen of \	What Countr	ry?
	h with	3317 Mont Clare	Lane				20715	5	United	Stat	es
	is within 72 hours after death with the Maryland liene. Than "natural", or terms 23a or 23a-1 ahow the Model Experies mottle mottle and ompleted by Funeral Director	11. Marital Status	12. Was Decedent E	ver in U,S. 1	3. Was Dec	edeni of H	ispanic Origin? n, Mexican, Pu	(Specify Yas or No erto Rican, etc.)	- 14. Rac Blac	e - America ck, White, e	
20	urs after it, or it is or it.		MXYes 2 □ No If Yes, Give Year or Dates:				Specify:		Specify	. Whi	te
00-	2 hours	15. Decedent's E	ducation	16a De	cedent's Us	uei Occup	etion		16b. Kind of B	usinass/Indu	ustry
215	C . N .	(Specify only highest gas Elementery/Secondery (0-12)	College (1-4or 5+	(G life	ive kind of w e. DO NOT	vork done d use retired	during most of v	vorking			
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and	SED O	17. Father's Name (First, Middle, Las Paul Klaassen	u)					Name (First, Middle Nhitese		10)	
Maryland 21215-0020	S D E E	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addre	ss (Street		Rurel Routa Numb		Stete, Zip (Code)
	nd 2 aith a 27 is r tra	Nadine L. Klaass	en Wif					Bowie M			
Baltimore,	20 50	20a. Method of Disposition ★☑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Di cematery, o	sposition (No crametory or	eme of other plea	e) Augus	t 18ate 19	9 30c. Location -	City or Tow	vn, State
Itim	permit. Page Department of Important: If I any Injury or page.	4 □ Donation 5 □ Other (Spec	ify)	Maryla	nd Ve	teran	s Cemet	ery	Chelter	ham M	laryland
Ba	Depa Impo any i	21. Signature of Funeral Service Lice	Parise Rich	2.	Rober	t E.		Guneral H			
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	npilcations that caused t	he death. Do not	16000 enter the mo	Anna ode of dyln	polis R	Rd. Bowie	Marylar rrest,		Approximate
	Physician	shock, or heart failure. List only	y one cause <i>on</i> each line).							Interval Between Onset and Deeth
M	/Medical Examiner	Immediate Cause (Final disease or condition	Lymph	oma						1	unknown
		resulting in deeth)	E	ue to (or as a con	sequence of	f):					
	n and latranak Examine	Secure tiethe liet and distance	l b	ue to (or as a con	sequence of	r\·					
oʻ				10 (01 83 8 007)	sequence of	·y.					
8760,	mysician the burial	Cause (Diseasa or injury that initiated events resulting in death) Last	c	ue to (or as a cons	sequence of):					
9 x	at the death certificate be d by the atlending physical etached for use as the bur Physician/Medical		d								
Box.	death d for u	Part II. Other significant conditions	contributing to death but	not reculting in th	o undodvina	nauca ahu	on in Part I	23h Did	tohacco usa co	atribute to	the causs of death?
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Rec	has by pe 2 a									of d	leath?
Vital	ov. pa	25. Was case referred to medical					26 Place of I	Death (Check only	Yes No	10	Yes 2 No
₹	hysician: his cartific if director, To Be (examiner?	Hospital: 1X Inpatien	t 2 ER/Outpa	tient 3 [OOA Oth	or:	g Home 5 Res		er (Specify))
0		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Dete of Injury (Month, Dey	Year) 28b. Tim-		28c. Injun Wor	y at k?	28d. Describe	how injury occur	red	
Division of		2 Accident Investigation	he	A1 h	M		Yes 2 No	29f Location	Street and Num!	har or Pural	Poute Number
ō.	after Atten after deal Director: I in by the ertifica	4 Homicide determined	28e. Place of Injur building, etc.	y - At nome, tam, (Specify)	street, racto	ory, office		City or To	Street end Numl wn, Stete)	or or murar	riodie Number,
T		29a. Certifier 1X Certifying P	hysician: To the best of	my knowledge, de	eath occurre	d at the tin	ne, date and pla	ace, and due to the	cause(s) and ma	annar as sta	ated.
/	H S S S S S S S S S S S S S S S S S S S	(Check only 2 Madical Exa	minar: On the basis of e end manner state		rinvestigetic	on, in my o	pinion, death o	ocurred at the time,	date and place,	and due to	tha cause(s)
	T T T T T T T T T T T T T T T T T T T	29b. Signature and titla of certifiar	001		2	9c. Licens	e number		29d. Data signe	d (Month, D	Jey, Year)
,	LUH		- 8			D3239	95		0/11/	//	
	(M) 2 505	Thomas Finucan,	M D VA Ma			Carr	Carabas	Desert F	oint M	D 210	303
	State	31. Date filed (Month, Dey, Year)	32. Registrer		ealth	care	System	, Perry F	oine, M	D_219	JUZ
	Registrar	AUG 1 3 1999	Block	19 1							

DHMH 16 Rav 6/95

Name Known to Physician: KLAASSEN, JAMES



Amend #26.	Per Phys. PGC 8-12-	State of Marylan		tificate of		Reg	ene g. No. 99	27036	
Physician /Medical	1. Decedent's Name (First, Middle, Last)			ee.		2. Date of Death Month July	25 1999		
• Examiner	4a Facility Name (If not institution, give street end number) Southern Maryland Hospital				4b. City, Town, or Location of Deeth Clinton 4c. County of Death Prince George's				
Funeral Director	5. Social Security Number 241-12-9603 6. Sex	7. Age (In yrs.	lest birthdey). 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dex.) Sept. 1	9. Bir	thplace (Stete or Foreign punity) orth Carolin	
To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunial-transit of manual certification: To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits	
	Maryland Prince George's			Clinton			1√ Yes 2□No		
	10e. Street and Number 9106 Pine View Lane			10f. Zip Code 20735			10g. Citizen of What Country? United States		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:		.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica			ecify Yes or No- Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired)			16b. Kind of Business/Industry		
	Unknown			Domestic Worker			Private		
	17. Father's Neme (First, Middle, Last) Eddie Maxwell				18. Mother'a Name (First, Middle, Meid Lizzie Ell				
	19a. tnformant's Neme/Reletionship (Type, Print) 19b. Meil			g Address (Street	Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)				
	Thomas Lee, Jr Son 154 Straw Ave., Pittsburgh, PA 15202 20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) Lee's Crematory 7/30/99 Clinton, MD							Town, State	
	4 Donation 5 Other (Specify) Lee's Crematory 7/30/99 Clinton, MD 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., D.C. 20019								
	23a. Part1. Anter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Converse of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Due to (or as a consequence of): Converse of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Due to (or as a consequence of): Converse of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Due to (or as a consequence of): Converse of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Due to (or as a consequence of): Converse of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Due to (or as a consequence of): Converse of the death Death Interval Between Onset and Death Interv								
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						24e. Was an performe		Were autopsy findings available prior to completion of ceuse of death?	
						1 ☐ Yes	2 ₹ No	1 Yes 2 No	
	25. Was case referred to medical examiner? 1 Yes 2 No								
								urar riodie riomber,	
	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steled. Check only one) Check only one) Check only one)								
To the comp	296. Signature and title of cardifier Lin A Sayan, MD.			29c. License number D-10085			29d. Date algned (Month, Dey, Year) 7 / 2 8 / 8 9		
		Sayan - 40	00 Mit		le Rd., Su	uite 306,	Bowie, M	D 20716	
State Registrar	31. Date filed (Month, Dey, Year) ALC 1 2 1999	32. Registrar's Signe	S.	Lovels					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #'s 10c.& 19b.Per FH PGC 8-11-99 cr 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** JOSEPH SINCLAIR LYLES 2110 Aug Copt 1999 /Medical 4a Facility Name (If not Institution, give street and number)
50/ 62 Avenue 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Seat Pleasant Prince 6 eones Avenu If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 10XM 2□ F Months Deys Hours 70 Yrs. Director 227-28-5027 December 18.28 Virginia Usuel Residance of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits Prince George's -Capitol Heights 1 Yes 2 No Mary 1 and Seat Pleasant Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 501 62nd Avenue, Apt #C 20743 U.S.A. Funeral 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 100 Never Merried 2 ☐ Married Specify: Black 1952 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Private Maintenance Worker 8th 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Alice Barnett Joseph McKinley Lyles 19b. Meiling Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code)
501 62nd Avenue, #C, Gapitol Heights, MD 20743 19a. Informent's Neme/Reietlonship (Type, Print) Joyce Lyles/Sister 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 08/16 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Maryland Veterans Cemetery Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility J.B. JENKINS FÚNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart fallows: List only one cause on each line. Approximate intervel Batween Onsat and Deeth Physician Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical CANCER **Examiner** Examiner Sequentielly list conditions, if eny, laeding to Immadiata cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in daath) Last Dua to (or as a consequence of) Physician/Medical Dua to (or es a consequanca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 □ Unknown 1 Yee 2 No þ 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of daath? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes care referred to medical exercitar? Be 28. Place of Deeth (Check only ope) Other: 4 Nursing Homa 5 Residence 2 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 6 ☐Other (Specify) 27. Menner of Deeth 28b. Tima of 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Netural 2 No 1 ☐ Yes 2 Accidant 6 Could not be datermined Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicida

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tem 27 is marked other than "natural", or forms 23a or 28a-f shot other traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer i Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event. In the content of the content traumatic event.

Baltimore, Maryland 21215-0020

physician and the buriel-transit 88 950 signed t After this funeral

or Attanding aftar death. Diractor: Aft Hospital
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 Funeral C To the Vithin 2

State Registrar

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29a. Certifier

(Check only one)

29b. Signeture end title of certifier

29c. License number Drive Cheverly, Mary land 20785

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred et the time, dete end pleca, and due to the cause(s) and menner stated.

1 Certifying Phyelcian: To tha best of my knowledga, death occurred at the tima, data and place, end dua to tha causa(s) and manner as stated.

29d. Dete signed (Month, Day, Year)

31. Dete filed (Month, Day, Year) 1 1999

32. Registrer's Signeture

State Registrar 31. Dete liled (Month, Day, Year)
AUG 2 3 1999

HACHARIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N KORGU 111 Per

b. foots

111 Penn Street, Baltimore, Maryland 21201

	Amend #	17	7. Per FH PGC 8-11		aryland	-	rtment of		d Mental Hy	giene	9 2	7039
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation					0d. Insida City Limits
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	th the	Director	10e. Street and Number		1	· · · · · · · · · · · · · · · · · · ·	10f. Zip Cod			10g. Citizen of		try?
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020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral	11. Maritel Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yas 2 1 If Yes, Give Year or Detes:	Ever in U,S. No	11	Yas, specify C	uban, Mexican, Pu No <i>Specify:</i>	(Specify Yes or No- arto Rican, etc.)	Specif		
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ANG 1 130 Comments

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		eg. No. 99	27040										
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E 6 H	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits										
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flan Manda Ma Ma Manda Ma Manda Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma	John Early Wakefield Naomi	Dell	Dell											
and	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number,	City or Town, State,	Zip Code)										
CTOM W	Sandra Laase - Daughter 2820 Eliston Street,	Bowie, Ma	aryland 2	0716										
0 -3 5 5	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, Stata										
Pages tent of mit if its	1	08/11/99	Brentwood	, Maryland										
Part of the last	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility	100/11/00		,										
n adia	Willia C. Amie Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781													
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(15)	Kobert Donegan My 057546 -	C (PIT)	00-01-	()										
(0)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			Fall Edit										
	Robert Donegan, M.D., 1050 West Perrimeter Road, And	rews Air F	orce Base,	MD 20762										
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State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, P.O. Box 68760,

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3a or	Funeral Director	1346 North Car	olina Aven	ue NE	E	2000	2			Unite		-
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ortar Injur		21. Signature of Funeral Service Lice	ensee		2	2. Name and Ad	ddres		-	Wasiiii	igcon	, DC
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or Attar aftar dee Director in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At ho	me, farm, si	reet, factory, offi	ice		28f. Location (City or To	Street and Numb vn, State)	er or Rura	al Route Number,
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9/		30 Name and address of person who	FVORE 1	401	1203	Quet	CK	sbury	Rd My	alboil	4 M	020781
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State of Maryland / Department of Health and Mental Hygiene

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Y.	Physician /Medical	JOHN DALGHREN MINOR, SR 08/ 08 99													
•	Examiner	4e Facility Name (If not institution, give Suburban Hospita		d Georget			vn, or Location of hesda, N		ounty of Death ontgome	ry					
	Funeral Director	5. Sociel Security Number 6. So 577–56–3030	ex 7. Age (XM 2□ F 87	in yrs. last birthday, Yrs.	Months Days	If Under a	Min. (Mon	of Birth th, Day, Year) /16/12		olace (State or Foreign ntry) irginia					
Ī	death with the Maryland rms 23a or 28a-f show Frant be notified at	Usual Residence of Decedant 10a. Stete 10b. County D. C.	1	Oc. City, Town or L Washi					1	10d. Inside City Limita 1 ☑ Yea 2 ☐ No					
	iter death with the Manylar r items 23s or 28s-f show item must be notified at item resil Director	10e. Street and Number 3555-10th St	., N.W.		10f. Zip Code	20010			U. S. A.						
020	urs after Mr., or he morph by Fu	11. Merital Stetus 1 Never Merried 2 Merried 3 (X Widowed 4 Divorced	12. Wea Decedent Even Armed Forces? 1 🖾 Yes 2 🗆 No It Yas, Giva Year or Detes:	er in U,S. 13. Army	Wes Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 🗓 No	lispanic Orig an, Mexican Specify:	gin? (Specify Yes , Puerto Rican, et		Bleck, White,	etc.					
21215-0020		15. Decedent'a Ed (Specify only highest grader) Elementery/Secondary (0-12) 11th	ucation de completed) Coilege (1-4or 5+)	(Give	dent's Usual Occup b kind of work done DO NOT use retired axi Drive	during most d)	of working		b. Kind of Business/Industry Transportation						
Maryland 2	should be filed and Mentel Hygical marked other imatic event, II	17. Father's Neme (First, Middla, Last)	or		axi Diive	18. Motha		First, Middle, Meiden Sumeme) Emma Johnson							
Baltimore, Mar	ges 1 end 2 ahr it of Health and if frem 27 ls m or other trsum	19e. Informent'a Neme/Relationship (7 John D. Minor, J 20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify	r. / Son	355 20b. Plece of Disp cemetery, cre	ing Addrass (Street 5 - 10th osition (Name of emetory or other place co Nation	N.W. Wa	shington 20c. Loca	D.C.	20010 own, State						
Balt	permit. Pa Departmen Important: any Injury once.	21. Signature of Funeral Service Licens	21. Signature of Funeral Service Licensee #0777 W.H. BACON FUNERAL HOME, INC. 3447 - 14th St., N.W. Washington, D.C. 20010 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, Approximate												
1	Physician /Medical	23a. Pert1. Enter the disease, or compands, or heart failure. List only of	olications that caused the one cause on each line.	e deeth. Do not en		ng, such as	cardiac or raspira	tory errest,		Approximete Intervel Between Onset and Death					
	Examiner Examiner	disease or condition resulting in deeth)	b	ua to (or as a conse	quence of):	1 //	EURO	VIA	1	IU VAYS					
ox 68760,	g physicia as the bur	Ceuse (Disease or injury that Initiated events resulting in deeth) Lest	c	e to (or es e conse											
.O. B	as that the deeth or gned by the attend be detached for us by Physician	Pert II. Other algniffcant conditions co	entributing to death but i	not resulting in the u	underlying causa giv	ven in Pert f.	238		4	o the cause of death?					
0		UROSEPS	,	ROMC		-		1 ☐ Yea 2 ☑ . . Was an autopsy		bebly 4 Unknown Vera autopsy findings					
Records,		INSUFFICEN	rcy; Ri	CHT CE		VASC	, ral	performed?	av	railable prior to impletion of cause death?					
of Vital F	certificate has rector, page 2	25. Was casa referred to medical examiner?	H LEFT	HEMI	PLEGO	26. Place	of Death (Check	1 ☐ Yes 2 ☑ only ona)	No 11	☐ Yea 2☐ No					
of	g Physician: er this certific ieral director, n: To Be (27. Manner of Death	Hospitel: Inpatient 28e. Data of Injury (Month, Day Y	1	MIC SLI DON		rsing Home 5 28d. Des	Reaidence 8 [cribe how injury of		(y)					
Division	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	1 Netural 5 Panding Investigation 3 Suicide 4 Homicide 5 Panding Investigation 6 Could not be determined		- At home, farm, st	M 1	Yes 2□I	28f. Loca	tion (Street and or Town, Stete)	Number or Run	al Routa Number,					
۵	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Ceri		refcian: To the best of n iner: On the basia of ex	caminetion and/or in											
	To the comple	29b. Signature and title of certifier	mma	mn.	29c, Licens	number	047	29d. Date	aigned (Month,	Dey, Year)					
	2	30. Name and address of partion who of JOSEPH D. ONN	ompleted cause of deal	th (Item 23a) (Type	Print) EXECUTION	IEBU	PROCK	VILLE,	mo o	20852					
	State Registrar	31. Data filed (Month, Day, Year) AUG 1 1 1999	32. Registrar's		books										

5:30 Pm

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JOHN MINOR

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

te	of	Maryland /	/ Dep	partme	ent of	Healtl	n and	Mental	Hygiene
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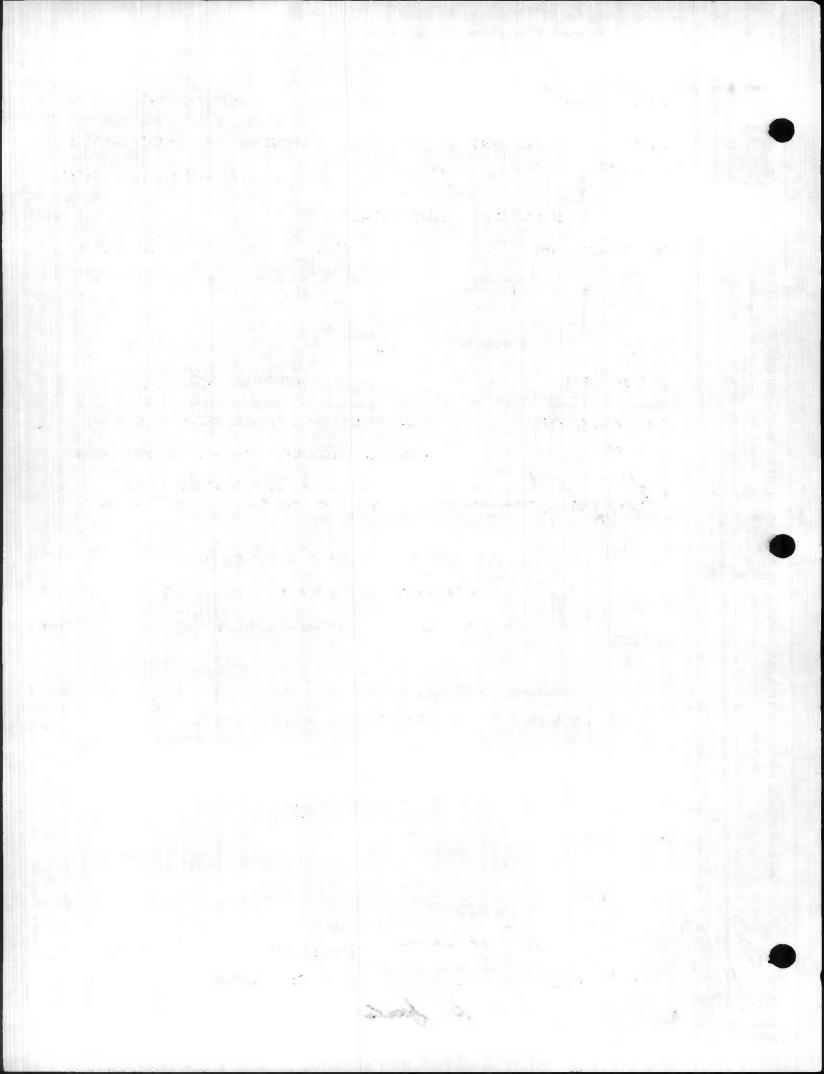
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						Cei	tificate d	of Death		Reg. No.			
	Physician · /Medical	Decedent's Nam NORMAN	ne (First, Middle, MOOR	,					2. Data of De AUGUST	1 1 ^{Day} 1 999		3. Tima of Death 9:30am	
	Examiner	4a Facility Nama ((If not institution,	give street and nun	nber)			4b. City, Town,	or Location of Death	4c. County	ol Death		
				URSING HO				RIVERI			GEORG		
	Funeral Director	5. Social Security (231-12-93	386	S. Sax 1∭M 2☐ F	7. Aga (<i>i</i> n <i>yr</i> s. 7		Il Undar 1 Ye Months Da		Hrs. 8. Data of Bird (Month, De	y, Year)	9. Birthplac Country VIRG	ce (Stete or Foreign /) INIA	
	yland	Usual Rasidanca o 10a. Stata	10b. County		10c. Cit	ty, Town or Lo	cation				10d	I. Inside City Limits	
	Mar at	MD	PRINC	E GEORGES	S	EAT PL	EASANT					Yas 2□No	
	h with the Ma 3a or 28a-f a at be notified	10e. Street and Nu 824 CARE		AVE			10f. Zip Cod 207			10g. Citizen of V UNITEI			
020	urs after death with the Maryla al', or terms 23a or 28a-f shoo Examiner must be notified at by Funeral Director	11. Marital Status 1 Nevar Marital Status	rled 2\(\overline{\chi}\) Marrie	12. Was Dece Armed For 1 Tyyes If Yes, Giv. Year or Da	rcas? 2 □ No a		Was Decedent I Yes, specify C		(Specify Yas or No uarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc. Specify: BLACK			
9			15. Decedent's	Education		16a. Deced	ient's Usual Oc	cupation		16b. Kind of B	usinass/Indus	stry	
21215	ed within 72 ho yglene. wer than "nature it, the Medical. Completed	(Spe		grede completed) Collega (1	-4or 5+)	(Give life. I	DO NOT use re	ne during most of tired)	working	PRIVAT	TE.		
Maryland 21215-0020	harmal Hygi ked other ic event, i	17. Father's Name WILLIAN		est)			Nama (First, Middle, DOLYN GOR)		10)				
ary	and M and M amment	19a. Informant's N	lame/Ralationshl	o (Type, Print)		19b. Mailir	ng Addrass (Str	eet end Number o	Rural Route Number	er, City or Town,	State, Zip C	ode)	
T.	and 2 sath 1 sr tra	VIVIAN N	MOORE/ W	IFE		824	CARRING	TON AVE,	SEAT PLE	ASANT, MI	2074	3	
Baltimore	Pages 1 sent of He rit: If Hen rry or oth			Ramoval Irom S	(Place of Disposition (Name of Data 200. Location - City or Town, Stata 200. Location - City or Town, S							
	Physician /Medical Examiner	Immediata Causa disaasa or condition resulting in deeth)	(Final	a. CA	aused the deaf	A C	2617 PE ar tha moda ol	NN . AVE dying, such as car	POPE FUN S.E. WASH diac or respiratory a	INGTON I	OC 200	20 oproximate ntarval Batween onset and Death	
Box 68760,	ot the death certificate be executed by the ettending physician end eteched for use as the bunal-transit Physician/Medical Examiner	Sequentially list or if any, leading to it causa. Enter Und Cause (Disease or that Initiated avant rasulting in death)	S		Dua to (c	or as a consac	uance of):	(566)			~	EARS	
		Part II. Other signi	ificant condition	contributing to da	ath but not ras	sulting in the u	ndarlying causa	givan in Part I.	23b. Dld	tobacco uae co	ntribute to ti	he cause of death?	
s, P.O	£ 90 >	M	Beul	-A A	~ 1	RES	TIMAL	DEGE	MEARCUA	Yes 2 No	3 Probe	bly 4 🗆 Unknow	
Vital Records,	aw requires the second of the									an autopsy rmed?	avalle	a autopsy lindings able prior to plation of cause eath?	
000	The la ate he page								10	Yas 2 2 10	10	Yes 2□No	
/ita	Physician: The rising certificate ral director, par ral Control of the Control of	25. Was casa rele axeminar?	rrad to medical					- 1	Death (Check only o	one)			
0	hya his T	1□ Yas 22	No			ER/Outpatier	it 3LJ DOA		g Homa 5 Rasi				
	After fune	27. Menner of Dee Netural 2 Accidant	5 Pending Investiga	tion	of Injury h, Dey Year)	28b. Tima o Injury		njury at Work? 1 ☐ Yes 2 ☐ No	28d. Dascribe	how Injury occur	red		
Division	pital or Attendours after deat and Director: filed in by the	3 ☐ Suicida 4 ☐ Homicida	6 ☐ Could no determin	ed 28e. Place	ol Injury - At h ng, etc. (Specil	ome, farm, atr	eet, lactory, off	ice	28f. Location (City or To	Street end Numb vn, Stete)	per or Rural F	Route Number,	
	Hospi 24 hou Funer tely fill	29a. Cartifiar (Check only one)	1 Certifying 2 Medicat Ex	Physician: To the caminer: On the ba and menn	sis of axamina	owledga, daati	occurred at the	a tima, data and p ny opinion, deeth o	ace, and dua to tha occurred et the tima,	causa(s) and mediate and place,	annar as stat and dua to th	led. ha cause(s)	
	Med Med	29b. Signature and	His of certifier	1	a veze a			ansa number		29d. Date signe	d (Month, De	ey, Year)	
1	(1)	1 6	10	//	oe	e		31069		August	12,	1999	
1	110/			D. 1100				TE 135, L	ARGO, MD	-			

32. Registrar's Signatura

State Registrar

31. Deta filed (Month, Dey, Year)
AUG 1 3 1999



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg	g. No.	16	. 1044		
			1. Decedent's Name (First, Middle, La							ete of Death	Day	(ans	3. Time of Deeth		
	Physicia /Medica	_	Richard H. M	angum					A ⁿ	ugust	[™] 6,199	9	1:15pm		
	Examine		4a Facility Name (If not Institution, given Holy Cross Ho					* '	own, or Location		4c. County of Montg		ry		
	Funeral Director		579-38-1526	Sex 7. Age 1×1 M 2□ F	(In yrs. las	t birthday) Yrs.	If Under 1 Yes Months Days		24 Hrs. 8. D Min. Ap:	ete of Birth Month, Day, 1 ril 1	(ear) 6,1932	Birthpl Count W	ace (State or Foreign ash.D.C.		
	Aaryland f show	٥	Usual Residence of Decedent 10a. State 10b. County Md. Montgom	erv		Town or Lo	cation Spring					10	Od. Inside City Limits		
	with the	Director	10e. Streel and Number 13606 Athania	-			101. Zip Code 2090	6		109	g. Citizen of Wh	at Count	ry?		
020	urs a	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedeni E Amed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates:	7947 1950		Ves Decedent of Yes, specify Cu	ban, Mexica	n, Puerto Ricar	Yes or No- n, etc.)	14. Race - Black, Specify:	White, e	itc.		
21215-0020	5 3	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		-	(Give	lent's Usual Occi kind of work don OO NOT use retir	e during mos ed)	st of working						
and 21	H od oth	9	17. Father's Name (First, Middle, Last Charles Man	'	F	'ire	Fighte	18. Moth	· ·		D.C.Fire Dept. Middle, Maiden Sumame) Dell				
Maryland	d 2 sho th and 7 is m traum	0	19e. Informent's Name/Relationship (Ethel Hellmann	Type, Print)		19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, St. 13606 Athania St. Silver Spring									
Baltimore,	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		COIT	e of Disponetery, crem	sition (Name of natory or other pi	ace)	De	ote 20	Oc. Location - Cl	ty or Tov			
Balt	pemit. Pag Department Important: I any Injury o pncs.		21. Signature of Funeral Service Licenses PHILIP D.RINALDI FUNERAL SERVICE 11818 New Hampshire Ave.Silver Spring, M												
	Physician /Medical Examiner		shock, or heart failura. List only Immediate Cause (Fine) disease or condition	one cause on each line	В.	Do not ente	er the mode of dy						Approximate Interval Between Onset and Death		
	3 3	niner	resulting in deeth)	· CORON	UAA	s a conseq	uence of): ARTE	SR1	DISE	NSE	5	5	Tyeaus		
ox 68760,	erificate be ang physicis as as the bu	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or Injury their initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
P.O. Bo	that the death or ed by the attend detached for us		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacc									cco use contribute to the cause of death?			
of Vital Records,	2 58	completed by								24a. Was an perform		ava	re sutopsy findings illable prior to npletion of cause leath?		
tal Re	delant. The law conflicate has rector, page 2		25. Wes casa raferred to medical							1 🗆 Yes		1	Yes 2 No		
5		Ď	examiner?	Hospital:	۰ ۵۵۰	210-testion	4 DOA 0	ther _	e of Death (Ch	_		10			
5	Affect fund	- -	27. Manner of Death 1 12 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day		WOutpatien Bb. Time of Injury	28c. Inj W		28d. l	17211111	ce 6 Dother)		
Division		Certifica	3 Suicide 4 Homicide 6 Could not b determined		y - At hom (Specify)	e, ferm, stre	eet, fectory, office	•		ocation (Stre Dity or Town,	eet and Number Stata)	or Aurai	Route Number,		
-)	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	COICAI	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to tha cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and menner stated.										eted. tha causa(s)		
1	Total Marie Communication of the Communication of t	2	29b. Signature and title of certifier					nse number	11-1		d. Date signed (
)			30. Name and address of person who	21 ND	ath (Itam 2	Sa) (Tuna 1	DO	013	456	1	44635	6	,1999		
			ALLEN OBE (31. Date filed (Month, Day, Year)	ER M.D. 32. Registrar			CHME	cod:	57 51	/VER	SPRING	141	20910		
	State Registrar	7	AUG 0 9 1999	General	4	1									

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WANNETTA			State	of Maryl						nd Me	entai Hy	giene	0	0	030	1 1 1-0
MEDLEY						erti	ficate	of L	Death			Reg. No.			2.70	4.5
Physician	1. Decedent's Nerr	na (First, Middle, Li	est)							4	2. Deta of Death Month Day Yaar 3. Tima of Death					of Death
/Medical	Wanr	netta	C. Me	dley							AUGUST			99	3:261	M.
Examiner	4a Facility Nama (umber)				4	b. City, Tov	vn, or Loca	ation of Deat	h 4c.	County	of Death		
		LBORO PII	Œ								IGHTS	PF	RINCE	E GEC	RGES	
Funeral Director	5. Social Security II 216-60- Usual Rasidence of	-9901	Sex 1□M 2점F	7. Age (In) 45	yrs. last birtho Yn	A	If Under 1	Year Days	If Undar 2 Hours	Min.	3. Data of Bir (Month, Da) 7/06	ly, Year)	54	Coun	lace (State try) land	or Foreign
Manual Ma	10a. Stete	10b. County		10c.	City, Town o	r Locat	tion							1	Od. Insida	City Limits
vith the Mary t or 28s-f sho be notified	MD	P.G.		L	andov	er									1 🏹 Ye	s 2 No
after death with the Maryland or items 23s or 28s-f show miner mat be notified at Funeral Director	10e. Street and Nu 7330 La	andover	Road	#C			101. Zip C	78	5			10g. Citi USA	izan of W	fhat Coun	try?	
	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No Specify:							in? (Spec , Puarto Ri	ify Yas or No can, atc.)		k, White,					
72 hours natural;		15. Decedent's E	1		16a. D	eceden	t's Usuel (Occupa	tion		16b. Kind of Businass/Industry					
withic with the control of the contr	Elemantary/Second 1 0	cify only highest gr ondary (0-12)		(1-4or 5+)	- (C	aive kin fe. DO	NOT use	done d retired,	uring most	of working		Sho	ppe		Food	
Sabs w	17. Fathar's Nama	(First, Middle, Last Mackal]	•								First, Middle	, Maiden	Sumam	e)		
Mc and 2 strike ar trau	And the second second	ame/Retetionship		S							Route Numb Orive					D 21
	20a. Mathod of Dis 1 Surial 2 4 Donation	b. Place of D cemetery, esurr	cremet	ory or other	of er place	в)	8	Date / 9 / 9 9			City or To		o,MD			
permit. Pages Department of Important: If it eny injury or ence.	21. Signature of Fi	unaral Sarvice Lice	nsee	(-)		22. N	lama end	Addres	s of Facility		dges Ed S					
	23 Part1, Entar I	tha disaase, or con	nolications thet	caused tha d	eath. Do not	99	the mode	of dvine	ver h				AMO	, INC	Approxim	ate
Physician /Medical Examiner	Immediata Cause disaase or condition rasulting in daath)	on		O GUY									/		Intarval B Onset and	atween
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ding ding	that initiated event rasulting in death)	Last	d	Dua to	o (or as a con	sequer	nce of);					_		1		
res that the death igned by the atter I be detached for u by Physician		ficent conditions	contributing to	death but not	resulting in th	ne unde	orlying cau	se give	n in Part I.			tobacco Yee 2				of death?
law requires that as been signed to a should be determined by P.											24a. Was	en eutopormed?	osy	av	ere autops allable prio apletion o death?	rto

Division of Vital Records, To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, pag Be Con Medical Certification: To

25. Was casa rafarred to medical examinar? 1X Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending Invastigation 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 8-4-99 1522 M 1 = 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify)

28b. Tima of Injury

28c. tnjury at Work? 1 Yas 2 No

28. Placa of Deeth (Check only one)

Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) SCENE 28d. Describe how injury occurred

Yas 2 No

Subject was shot
281. Location (Street and Number or Rural Route Number, Pitto
City or Town, State) 4801 Manbaro 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, end due to the causa(s) and manner stated.

1 Yes 2 No

29e. Certifiar (Check only one)

3 Sulcide 4 Homicide

> 29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Nem 23a) (Type, Print)

AUGUST 5,1999

State Registrar Stephen S, 31. Data tildd (Month, Day, Year) AUG 0 9 1999

2. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

Alphonso McLean

Months

10f. Zip Code

State of Maryland / Department of Health and Mental Hygiene

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1	- 1		1.5	1
6.	1	w	7	100

AMEND: #	23 PART	I,II	,27	PER	MEO	G776	Certificate o	f Death
	1. Decedent's Nam	e (First, Mi	ddle, Last)				
Physician /Medical	ALPHON:	SO SO	S.	A	ICLEA	٧		
Examiner	4a Facility Name (I	f not institu	tion, give	street and	number)			4b. City, To
	Greater	Laure	J. Ho	spita	J.			La

Directo

Funeral

þ

Completed

Be

2. Date of Death Month August 13, 1999 4b. City, Town, or Location of Death

3. Time of Death 1:15 P.M.

5. Social Security Number **Funeral**

Greater Laurel Hospital

Laurel If Under 24 Hrs. If Under 1 Year

Days

4c. County of Death Prince George's

252-60-6421

7. Age (In yrs. last birthday) 1**X** M 2□ F 59

8. Date of Birth (Month, Day, Year) Hours Min.

 Birthplace (State or Foreign Country) AUGUSTA,

Director

show

28a-f

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Вети 23а

of Hygiene. Other than "natural", or them

Pages 1 and 2 should be nent of Health and Mental.

Department of Health at Important: If Iham 27 is any injury or other trau 2008.

Physician

/Medical

Examiner

sician and burial-transit

\$

signed by the

page 2

The law requires that the deeth certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Physician:

or Attending

Hospital

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deeth.

24 hours after deet Puneral Director:

within 24 ho To the Fune completely fi

filled In

this

After

Examiner

Physician/Medical

λq

Completed

8

Certification: To

Medical

.

21215-0020

altimore, Maryland

10a. State MD

11. Marital Status

PRINCE GEORGE

10c. City, Town or Location BELTSVILLE

1 Yes 2 □ No 10g. Citizen of What Country?

10d. Inside City Limits

10e. Street and Number

13115 GREENMOUNT AVENUE

10b. County

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 M No If Yes, Give Year or Dates:

20705 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

U. S. A. 14. Race - American Indian, Black, White, etc.

1 Never Married 2 Married

3 ☐ Widowed 4 ¥ Divorced 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BLACK 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+) + YEARS

MORTGAGE BROOKER

REALATOR

17. Father's Name (First, Middle, Last)

ALPHONSO F. MCLEAN

FREDDIE STONE

19e. Intormant's Neme/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10169 N. H. AVE.

18. Mother's Name (First, Middle, Maiden Sumame)

#196 SILVER SP., MD 20903

EDWARD B. MCLEAN - BROTHER 20a. Method of Disposition

1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

LINCOLN MEMORIAL CEMETERY 8/23/99 SUITLAND, MD 22. Name and Address of Facility
PINCKNEY-SPANGLER FUNERAL HOME

21. Signature of Funeral Service Licenses

23a. Part1. Enter the disease, or complications that caused the death. Perh shock, or heart tailure. List only one cause on each line.

inclinity 524 -8TH ST., N. E. WASH., D. enter the mode of dying, such as cardiac or respiratory errest,

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

HYPERTENSIVE DISEASE AND RENAL FAILURE

ATHEROSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

DIABETES MELLITUS

ATRIAL FIBRILLATION

6 Could not be determined

1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

1 X Yes 2 No Yes 2 No

25. Wes ease referred to medical examiner? 1 ☐Yes 2 ☐ No 27. Manner of Death

1 Netural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Hospital: 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Cartifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

26. Piace of Death (Check only one)

O.C.M.E.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number MD

29d. Date signed (Month, Day, Year) August 18, 1999

30. Name and address of person who completed cause of death (flegues) (Type, Print) Strohen 5, -adentz

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

AUG 2 0 1999

32 Registral's Signature

Backer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month 4e. Fecility Nama (If not Institution, giva street and number) 08 15 1999 10:30 AM 4b. City, Town, or Location of Deeth 7. Aga (In yrs. last birthday) If Under 1 Year Months Days Hall Narsing Home ocomoke City MD If Undar 24 Hrs. 8. Dete of Birth Hours Min. Month, Day, Year) Norcester , 9. Birthplaca (Stata or Foreign Country) 1□ M 2**P**/F 213-30-725-8 Usuel Rasidanca of Dacedent Virginia 10b. County 10c. City, Town or Location 10d. Insida City Limits mo Worcester Pocomoke 1 Yas 2 □ No 10e. Straat and Numbar 10f. Zip Code 10g. Citizen of What Country? 1006 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Biack, Whita, atc. 11. Maritei Status 1 □ Never Merriad 2 □ Married 1 ☐ Yas 2 ☑ No Specify: Specify: Wkite 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decadant's Education 16b. Kind of Businass/Industry (Specify only highast grade complated) Elementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker 5 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Joshua Mae Tarr 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Nama of cematary, cramatory or other place) ChroTeague Va 23331 Kathryn 20a. Mathod of Disposition Data 1 ☑ Buriei 2 ☐ Cremation 3 ☐ Ramoval from State Surryridge Men Perk 22 Nama and Addrass of Fecility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvica Licensee 23a. Part1. Enter the disease, or completions that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feliure. List only the cause on each line. Immedieta Ceusa (Final diseasa or condition rasulting in death) Dua to (or as a consequence of) Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

the burial-transit

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Be Completed

Medical Certification: To

and

r this certificate has been si inal director, page 2 should

To the Hospital or Attending Physicien: Within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by the funeral director;

Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10a State

Funeral

Director

If item 27 is marked other than "naturel", or items 23s or 28s-(show or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or iten eny injury or other traumatic axa...

Baltimore, Maryland 21215-0020

the Maryland

death

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai

	- 0					
	cant conditions contrib					
arte	rioscle	cotio	Car	Leova	scular	/
	se; Aus					
Sasta	se; ans	uen	Legi	ndent	Mao	eli

nellitus; Caronary Certery Disease 26. Place of Death (Check only ona)

25. Was casa rafarrad to medical 1 Yes 2 No 27. Mannar of Death

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28c. Injury at Work? 28d. Dascribe how injury occurred

1 Natural 2 Accidant 3 Suicida

4 Homicida

5 Pending invastigation 6 Could not be determined

1 ☐ Yas 2 ☐ No 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

1 Certifying Physician: To tha bast of my knowledga, daath occurred et the tima, date and place, end dua to tha causa(s) and manner as stated.

2 Medical Examiner: On tha basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha tima, dete and piece, and dua to tha cause(s) and mannar stated.

29b. Signature shid title of certifier

29c. License numbar

29d. Data signed (Month, Day, Year)

Elgerio Name and add ess of person who completed causa of death (Item 23e) (Type, Print)

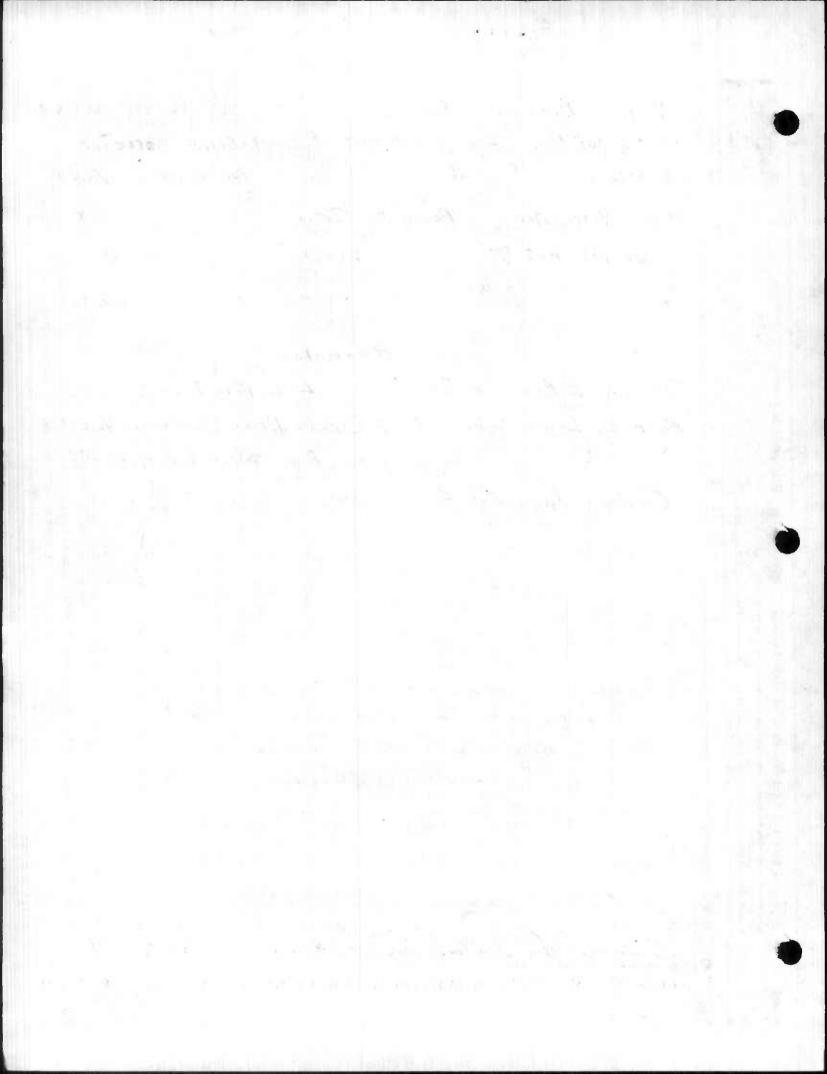
GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD; 2180]
31. Data filad (Month, Day, Year) 32. Registrer's Signatura

State Registrar

AUG 17



Sporks



Physician /Medical **Examiner**

Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KON ms: #23	Part	I,	State of	of Ma	ryland Meo	d F	epa Cen	rtmen	t of h	lealth a	and N	Mental Hy	gie Rea	2	9	270	18
1. Decedent's Name VAN D.	a (First, Middl	e, Las										2. Dete of Do Month AUGUS	eath	Dey	Year 999		of Death L3 PM
4a Facility Name (III					VTER						wn, or L EVER	ocation of Deal	th	4c. County PRI		GEORGE	ES
5. Sociel Security N 579-76-0		6. S	ex M 2□F	7. Age	(In yrs. le 42	1 yrs. last birthday) If Under 1 42 Yrs. Months			1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D. July 13,	ay, Year) Co			nplace (State untry) t Virg	
Usual Residence of	Decedent																
10a. Steta	10b. County				10c. City			ation								10d. inside	City Limits
Maryland	Princ	e (Georye'	S	Lai	ndo	ver										
10e. Street and Nur	nber							10f. Zip	Code				10g	. Citizen of	Whet Co	untry?	
3412 Dod	ge Parl	k,	#103						20	785				U.S	.A.		
11. Maritel Status 1 Never Merri 3 Widowed	_		12. Was Dec Armed For 1 Tyes If Yes, Gi Year or D	orcea? 2] X]No ive		S	H	/as Dece Yes, spe ☐ Yes	city Cub	lispanic Ori an, Mexicar Specify:	, Puerto	pecify Yes or No Rican, etc.)	0-		ck, White	rican Indian, a, etc. lack	
(Spec	15. Deceden		lucation da completed)			16a.	Decede (Give k	ent's Usua	el Occup	etion during mos	t of work	ing	16	b. Kind of B	usiness/l	ndustry	
Elementery/Second 12			College (1-4or 5+	.)	(Give kind of work done during most of working life. DO NOT use relired) Auto Body Repairman								Pri	vate		
17. Fathar's Neme (First, Middle,	Last)								18. Mothe	er's Nem	e (First, Middle	, Me	iden Sumer	ne)		
James Mi	xon									Pea	arli	e Harri	S				
19e. Informant's Ne	me/Reletions	hip (7	Type, Print)			19b.	Meiling	Address	(Street	and Numbe	er or Ru	al Route Numb	er, C	ity or Town	State, Z	(ip Code)	
James Mi	xon/Fa	the	er			72	212	East	Ki	Lmer S	Stre	et, Lan	do	ver,	Mary	land 2	20785
20a, Method of Disp 1 Buriai 2 0 4 Donation	XCremetion			Stete	Ce	meter	y, crem	ition (Nametory or o	other ple		1	08/24 1999				Town, State Mary	land
21. Signeture of Fu	neral Service	Lican	500							ss of Facilit							
Nan		Δ	P		+:			_				AL HOME , Lando		r. Ma	rula	na 205	785
23a. Part1. Enter the shock, or hear	ne disease, or nt teilure. List	comp	olications that one ceuse on	caused t	he deeth.	Do n									2714	Approxim Intervel B Onset an	ate etween
Immediate Cause (disease or condition resulting in death)			ā					IVE							-		
				D	ue to (or	as e c	onsequ	ience of):							1		
Sequentially list con if any, leeding to im	nditions, mediete		b. ———	D	ue to (or	es a c	onsequ	ence of):									

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow any Injury or other traumatic avent, the Madral Examinar must be notified at

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

2

Be Completed by Physician/Medical Examiner weral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bunal-transit Medicai Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed

After this certificate has

within 24 hours after death. To the Funeral Director: A

compietely

Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as e consequence of):

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wuknown 24a. Was en eutopsy performed?

1/2 Kes 2 No 25. Wes case reterred to medical axaminer? 26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xxas 2□ No 1 Inpatient 2 XBR/Outpatient 3□ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29e. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Addical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

30. Neme and address of person who ted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

24b. Were autopsy tindings evailable prior to completion of cause of death?

Xes 2 No

29d. Date signed (Month, Dey, Year) AUGUST 22, 1999

State Registrar

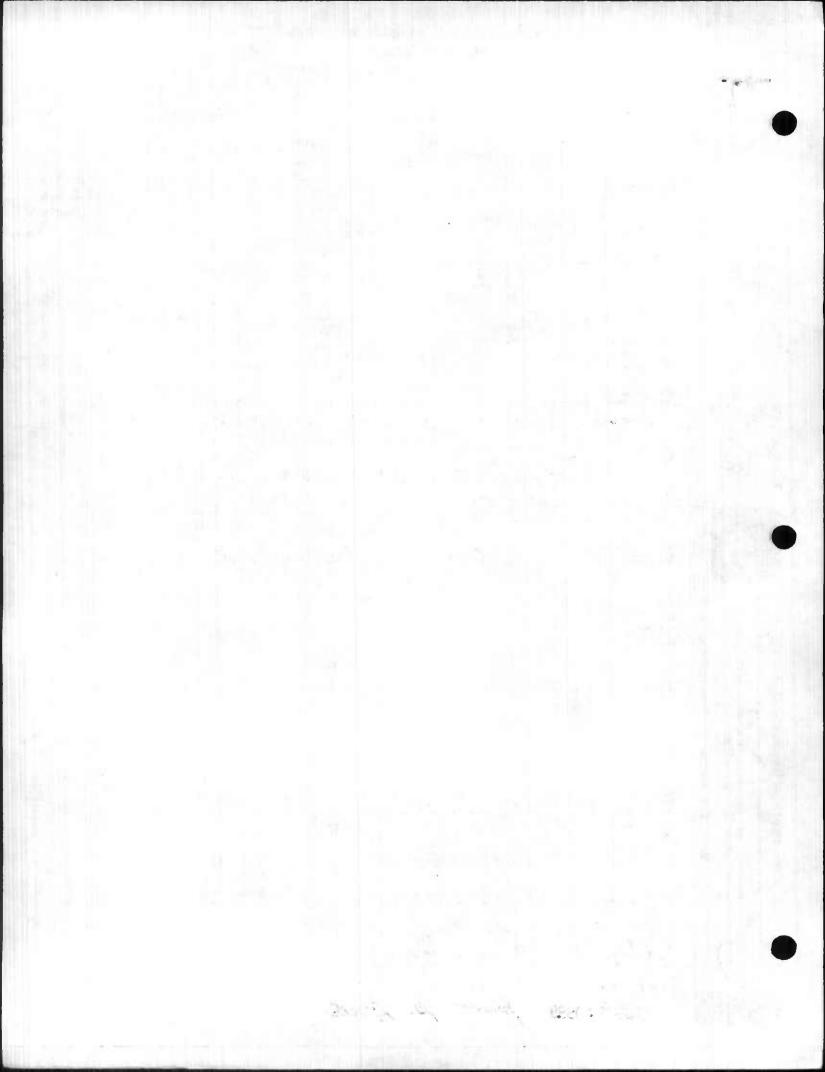
31. Dete filed (Month, Dey, Year) AUG 2 4 1999

29b. Signature and title of certifier

hutero 32 Registrar'a Signature



	own 99-1. Pedro Ca:		ro Perez	State of	Maryla				teaith and N <i>Death</i>	nental Hy	glene g	9 2	7049
*		_	1. Decedent's Neme (First, Middle,	Last)						2. Date of De	eeth	Vers	3. Tima of Death
	Physicia: /Medica	_	Pedro Castro	Perez						Month July	Dey 199	Year	4:15 A.M.
	Examine		4a Fecility Neme (If not institution,		ber)				4b. City, Town, or L				4.J.A.M.
100	Funeral Director		Unknown		. Age (In yrs	:. last birthday) Yrs.	If Under Months	1 Year Days	Langley I If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, Di 06-06	Prince oth ay, Year) -59	9. Birthp	rge's blece (Stete or Foreign htry) temala
	D .	-	Usuel Residence of Decedent 10a. State 10b. County		1100 0	ity, Town or Lo	ontion					1.	Od leade Other Line
	anyle ahor	_		0 1	100.0	aty, Town or Lo	Cation					1	0d. Inside City Limits 1 ✓ Yes 2 □ No
	N of Branch	Director	110	George's	H	yattsvi.							
	6 8 8	5	10e. Street and Number				10f. Zip				10g. Citizen of 1	What Cour	itry?
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020	or and	by ru	11. Mentel Stetus 1 □ Never Married 2 ☐ Merrie 3 □ Widowed 4 □ Divorced	Armed Force	es? No		Yes, spec		dispanic Origin? (Sp an, Mexican, Puerto Specify: Guat	Rican, etc.)	Specify	ck, White,	
Maryland 21215-0020	within 72 hours one. than 'natural', of	Сотріете	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4	lor 5+)		kind of wor DO NOT us	rk done se retire			16b. Kind of B		
2	Hygier ther th		2nd			Land	scape	r			Self Er	-	ed
and	8 = 9 2	ď	17. Father's Neme (First, Middle, Li	ast)					18. Mother's Nem	e (First, Middle	, Maiden Sumen	ne)	
Yes	Mer of	0	Domingo Castro			1 5 - 6			Victoria				
Mai	N 6 6 2		19e. Informent's Name/Reletionshi			1			and Number or Rur				Code)
	1 and 2 Heelth em 27 I	-	Julio Cesar Cas	tro Najer					t. Hyatts				0
0	9 5 2 0	1	20a. Method of Disposition 1 S Burial 2 □ Cremetion 3	Bamoval from St	ates	Place of Dispo- cemetery, cren	netory or o	ther ple	ce)	Dete	20c. Location -	City or To	wn, Stete
ti m	artmen ortant: Injury		4 Donation 5 Other Spr	19(4)	F	amily (Guatema	ala C	ity
Baltimore,	permit, Page Department of Important: If eny injury or page.		21. Signature of Funeral Service to) (a) L)- Mol				ss of Facility N FUNERAL Street N			, D.C	. 20010
H		1	23a, Part1, Enter the disable, of c shock, or heart fallure. List or	omplications that cau	sed the dea	ith. Do not ente	er the mod	e of dyir	ng, such es cardiac	or respiratory a	arrest,	-	Approximete Interval Between
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60,		a cxamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	O	Due to (or es a conseq	uence of):						
Box 68760,			that initieted events resulting in death) Last	d	Due to (or as a consequ	uence of):						
m	death cert	5	Dari II. Other elections and disco		h h- h h	- Mi i- M		t	on to Book to	ont Did	Ashasas		the same of death 0
P.O.		2	Part II. Other significant condition	s contributing to deat	n but not re	sulting in the ur	nderlying ci	ause gr	en in Pert I.		Yes 2 No		o the cause of death? bably 4 ☐ Unknown
Records	aw requir	piered by			_					24a. Wes	s en eutopsy ormed?	av co	ere eutopsy findings allable prior to impletion of cause death?
	The laste has page	5								100	Yes 2□No	11	Yes 2□ No
Vital	certificate rector, pag		25. Was case referred to medical examiner?						26. Place of Deel	h (Check only	one)		
o	this raidi	2	Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident investiga	28a. Date of (Month,		28b. Time of Injury		8c. Injui Wo	4 LI Nursing Ho		idence 6 XIOth how injury occur		wat scene
Division	5455		3 ☐ Suicide 6 ☐ Could no determin	ed 286. Place of	Injury - At I , etc. (Spec	nome, ferm, stre ify)	eet, fectory	, office			(Street and Numb wn, State)	ber or Rura	il Route Number,
	To the Hospital Within 24 hours To the Funeral completely filled	200		Physician: To the be taminer: On the basi and manner	s of examina								
	To the transfer of the transfe	-	29b. Signature end title of certifier	, 1		,	290	. Licens	e number		29d. Date signe	d (Month,	Dey, Year)
	(5)	3	Atys of person wi	ho completed cause	of death (Ite	m 23a) (Type, I	Print)		O.C.M.E.		July 04,	1999)
	State		Stephen S 31. Dete filed (Month, Dev. Year)	, Rac	len7	$^{\dagger}Z$, †		enn	Street, E	Baltimo	re, Mary	land	21201
	Registrar		AUG 2 5 199	39	and of	Ø. ,	Loca	Ra					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Physician Lillian Bryant August 4, 1999 1:10pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince George's 5. Social Security Number 6 Sax If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 E Months Days Hours Min. Yrs. Director 226-16-9349 88 Oct. 21, Virginia Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examinar must be notified at Maryland Prince George's Clinton 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pemit. Pages 1 and 2 ahould be filed within 72 hours eiter death v Department of Heelth and Mental Hyglans. Important: If New 27 is marked other than "natural", or frama 23a existing or other treumede avent, the Medical Examiner mast and 13002 Jervis Street 20735 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2nd Peanut Sorter Birdsong Peanut Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Bryant Alice Crutchfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Taylor/ Daughter 13002 Jervis Street Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☑ Removal from State 8/7 /99 Courtland, Va. 4 ☐ Donation 5 ☐ Other (Specify) Helping Hand Cemetery 22. Name and Address of Facility Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Licensee 04/485 5538 Marlboro Pike/Forestville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. 20747 Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Carcinoma of The Pancreas Months Examine Due to (or as a consequence of): Physician/Medical Examiner physician and the buriel-transit The lew requires that the deeth certificate be asscuted Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): US0 88 attending p signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Arteriolosclerotic Cardiovascular Disease Division of Vital Records. 2 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? paga 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2⊠ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending I Director: Aft of In by the fur 1 Yes 2 No investigation 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Mospital 24 hours e Funeral D edical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fl niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) \$ 29b. Signature and title of contilled 29c. License number 29d. Date signed (Month, Day, Year) D19731 August 5, 1999 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) 6 Frank Ryan M.D. 11701 Livingston Rd. #203 Ft. Washington, Md. 33 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 0 1999

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				aryiano		ertificate of		wientai H	Reg. No.	9 2	7051
Physici		1. Decedent's Name (First, Middle)	Last) Pete	2 VC				2. Date of D	Day	Year	5:45 Am
/Medi Examir		4a. Facility Name (If not institution,					4b. City, Town, or	Location of Dec	ith 4c. County		O.40 MM
-2011111		MARINER HEALTH			ZLAND	,	CLINTON			CE GEOR	CEIC
Funeral	Г		6. Sex 7. Ag	e (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of B		_	e (State or Foreign
Director		578-26-9573	1□M 20X1F	90	Yrs.	Months Days	Hours Min.	June 01	, 1909	Maryl	
pu &		Usual Residence of Decedent 10a. State 10b. County		100 Cib.	Taum and						
sho	2		· Coommole		Town or L					10d.	Inside City Limits 1X Yes 2 □ No
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permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Pyglene. Important: if Item 27 is marked other than "natural", or itema 23a or 28a-f show ship highty or other traumatic event, the Medical Experiment must be recitled at once.	by Fur	1 Never Married 2 Marrie	If Yes, Give	No		If Yes, specify Cub. 1□ Yes 2☑ No	an, Mexicen, Puert Specify:	o Ricen, etc.)		ck, White, etc.	
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2 sho and is me		19a. Informant's Name/Reletionshi			19b. Mail	ing Address (Street	and Number or Ru	ral Route Num	ber, City or Town,	State, Zip Co	^{de)} 20781
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Dhariston		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused nly one cause on each tir	I the death. ne.	Do not er	iter the mode of dyir	ng, such es cerdiac	or respiretory	errest,	Int	proximate erval Between isel and Death
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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

				State of Maryland		cate of			Reg. No.	2	7052
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	(/ /)) K. A	an SI MM		D25	640		08-11-	99	
	(0)	-	30. Name end eddress of person who of	completed cause of death (Item	23e) (Type, Print	1)			55-11-	55	
			K. Davachi, MI	1328 Sout	thern A	ve.	#202, Wa	sh.,	DC 200	32	
	State	-	31. Dete filed (Month, Dey, Year)	32. Registrar's Signal							
	Registra	r	AUG 1 3 1995	District D.	A Charles M.	4					

Justin William

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 1999 12:10PM Kathleen Hix Poag August /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery Hours Min. 8. Dete of Birth (Month, Dey, Year) Dec. 9, 1911 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 KF Deys Yrs. 87 Tennessee 302-09-7007 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Nashville Davidson Tennessee 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 37209 2917 Albion St. United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritel Status Bleck, White, etc. African 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: PV 3 XWidowed 4 ☐ Divorced American Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 5+ College Professor Private 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Walter Hix Eunice Pearl Jones 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 215 Oneida St., N.E. Wash., D.C. 20011 Dr. Lois A. Poag-Ray - Daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) 8/16/99 Greenwood Cemetery Nashville, Tennessee Stewart Funeral Home 22. Name end Address of Fecility 21. Sigrigiture of Funeral Service Licenses 4001 Benning Rd., N.E. Wash., D.C. Inter the disease, or complications that caused the detail. Do not anter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition rasulting in daath) Depos Due to (or as e consaquance of) Physician/Medical Examiner Dua to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disaasa or Injury Cerebral infraction that initieted events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chini renal failure à 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Vas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa raferred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 20 No 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Matural 5 Panding 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Sulcide Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 1 reflifying Physician: To the bast of my knowledge, death occurred at the time, data end piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Cartifian edical (Check only 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Nama end eddress of person who complated cause of deeth (Item 23a) (Type, Print) Rosen 5 3941 Ferrara Drive 20906 Mark M Silver 31. Dete filed (Month, Dey, Year) 32. Ragistrer's Signeture

State Registrar

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.
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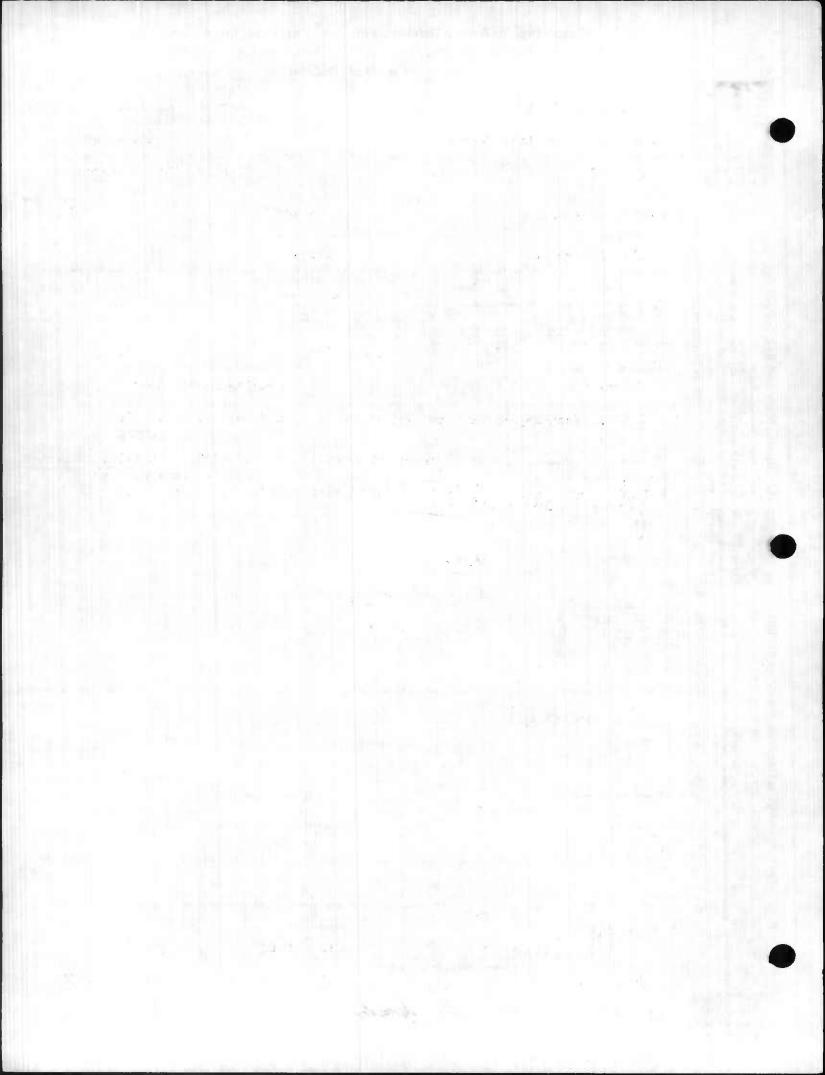
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To the To the

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



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the funeral offector.	Certification: 10 be	examiner? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No th 5 Pending investigatio 6 Could not b	28e. Date (More	of Injury of Injury e of Injury - At ling, etc. (Spect a best of my kr vasis of examir	28b. Time of Injury home, ferm, si	M 2 M reei, factory	8c. Injur Wor 1	er: 4 Nur y et k? Yes 2 N	No I place,	me 5 Res 28d. Describe 28f. Location (City or To	idenca 6 Oth how Injury occu (Street end Num wn, Stete) ceuse(s) end m	ber or Rura	al Route Number,
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he Funeral Director: After this certific pletely filled in by the funeral director.	edical Certification: 10 be	examiner? 1 Yes 2 27. Magner of Dee 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	No th 5 Pending investigatio 6 Could not be determined	28e. Date (More	of Injury of Injury e of Injury - At ling, etc. (Spect a best of my kr vasis of examir	28b. Time of Injury home, ferm, si	M 2 M reei, factory	8c. Injur Wor 1	er: 4 Nur y et k? Yes 2 N ne, date and pinion, deett	I place,	me 5 Res 28d. Describe 28f. Location City or To and due to the red at the time,	how Injury occu (Street and Num wn, State) cause(s) and m date and placa	nanner es s	al Route Number, tated. the cause(s)

LINDA D. GREEN, M.D., 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

Registrar DHMH 16 Rav 6/95

State

31. Date filed (Month, Dey, Yeer) AUG 1 0 1999

- Liles Kill

Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible.

ROBERT

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

RYAN

State of Maryland / Department of Health and Mental Hygiene

10f. Zio Code

ficate of Death	9.9	
icate of Death	Reg. No.	
	2. Data of Death	

	•
ψ	B + F
	Physician
	/Medical
	Examiner

Robert В. Rvan 4a Facility Nama (If not institution, give street and number) 19820 PINEBARK WAY

1. Decedent's Name (First, Middle, Last)

AUGUST 4b. City, Town, or Location of Death

3. Time of Death 4, 1999 2:55P.M.

Funeral Director

> r 28a-f show notified at show

Berrie 23s or

"natural", or

Hyglens. other than

permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event

Physician

/Medical Examiner

physicien and the burial-transit

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

edical

Director

Funeral

P

Completed

Be

053-34-7646 Usual Rasidenca of Decedant

7. Aga (In yrs. last birthday) Months 125 M 2□ F 56

BRINKLOW If Under 1 Yaar If Under 24 Hrs. Days Hours

4c. County of Death MONTGOMERY

10g. Citizen of What Country?

United States

10a. Stata

10b. County

10c. City, Town or Location

8. Data of Birth (Month, Day, Year) Aug. 19, 1942

18. Mother's Name (First, Middle, Maiden Surname)

Data

19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

 Birthplaca (State or Foreign Country) Jamaica, N.Y.

10d. Inside City Limits

Maryland

5. Social Security Number

Montgomery

Brinklow

1 Yas 2 □ No

10e. Street and Number 19820 Pinebark Way

11 Marital Status 1 Nevar Married 2 Married 12. Was Decadant Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yas 2 ☑ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: Black

3 ₩ Widowed 4 Divorced

15. Decedant's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

Collega (1-4or 5+)

General Service Administrator

20862

Government

17. Father's Nama (First, Middle, Last)

Unknown

Unknown

19s. Informant's Neme/Reletionship (Type, Print)

5201 Central Ave. S.E. #8 Washington, D.C.

20c. Location - City or Town, Stata

Mary Lorraine Guthrie 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other ptace) Chesapeake Crematory, Inc. 8/10/99 Beltsville, Md.

21. Signatura of Funaral Sarvice Licogsaa

22. Nama and Addrass of Facility
Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

20747 Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

ATHORNOS WENOTE CAMPION DESTAR AND

DIABOTOS HELLTHS COMPLICATED BY ENVICONHOLINA

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceusa (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of)

Dua to (or as a consequence of) HYPERTHENHID

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings svallable prior to

2 No

26. Place of Death (Check only one)

completion of causa of death? 1 Yes 2 No

25. Was case rafarred to medical axaminar? 1 XYas 2 No

27. Mennar of Death

1 Dilatural 2 Accident

3 Suicide

4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Panding invastigation tours 8-4-99

28b. Time of 12278

28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify)

RETITIONIS

28c. Injury et Work? 1 Yas 2 HO

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) TEMPONDER 28d. Describe how injury occurred FOUND IN FOOM WITH ELEVORA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 19820 PINE DAME WAY WONTGOWNY

29a. Certifian (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian

29c. License number

29d. Data signed (Month, Day, Year)

Soll Ulivile

6 Could not be determined

O.C.M.E.

AUGUST 5,1999

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

MARYAMOR 31. Data filed (Month, Day, Year) AUG 1 0 1999

A. KORTU 32. Registrar's Signatura

the death certificate be executed Box 68760 0.0 signed to pege 2 s

Records. Division of Vital this Attending 24 hours after death.

Funeral Director: At 6 filled in Hospital completely

> State Registrar

To the F Within 2

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Amend #23a.Part 1.Per Phys. PGC 8-13-99 cr Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Thomas Roness 10:38 11 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland social Security Number 6. Sex Baltimore medical Center Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2□ F Director 099-40-7180 8, 1949 New York Aug. Usuel Residence of Decedent death with the Maryland 10a State 10h Count 10c, City, Town or Location 10d. Inside City Limits show must be notified at Md. Prince Georges Bowie 10XYes 2 No Director 28e-f 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 20715 USA 23a 2406 Kegwood Lane Funeral Nems 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 Never Merried Merried 1 ZYes 2 No If Yes, Give 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: p Yeer or Detes: Vietnam 3 ☐ Widowed 4 ☐ Divorced 'natural' White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Consultant Financial Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even Be Aileen Gahan Walter Roness 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Kegwood Lane, Bowie, Md. 20715 Mary M. Roness 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 08-15 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) permit. Page Department of Important: If any Injury or once. Metropolitan Crematory Alexandria, VA. 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Shannon W. Beall M00798 Beall Funeral Home 6512 N.W. 20715 Crain Hwy., Bowie, Md 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate fntervel Between Onset and Death **Physician** lweek /Medical fmmediate Ceuse (Finel SEPSIS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): CHRONIC RENAL FAILURE vear The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medicai Due to (or es a consequence of) 080 signed by the a Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 □ No 1 Yes 2 No 25. Was casa referred to medical 26. Place of Deeth (Check only one)

Box 68760. P.O. Division of Vital Records, certificate Attending Physician: funeral director. Certification: To this After death. after death Director:

filled in by Hospital of 24 hours a
 Funeral D **Incletely** To the To the

9

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospitel: 1 Inpatient

28a. Dete of Injury (Month, Day Year)

University of maryland medical center, Baitinore, mb 21201 William C. Chiu 32. Registrer's Signeture M.D. 31. Dete filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner steted.

29c. License number

28c. Injury et Work?

1 Yes 2 No

046147

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

AUG 1 3 1999

5 Pending

investigation

6 Could not be determined

William C. Chin, m.D.

1 Yes 2 No

27. Menney of Death

1 Netural

2 Accident

4 Homicide

(Check only one)

29b. Signeture end fitte of certifier

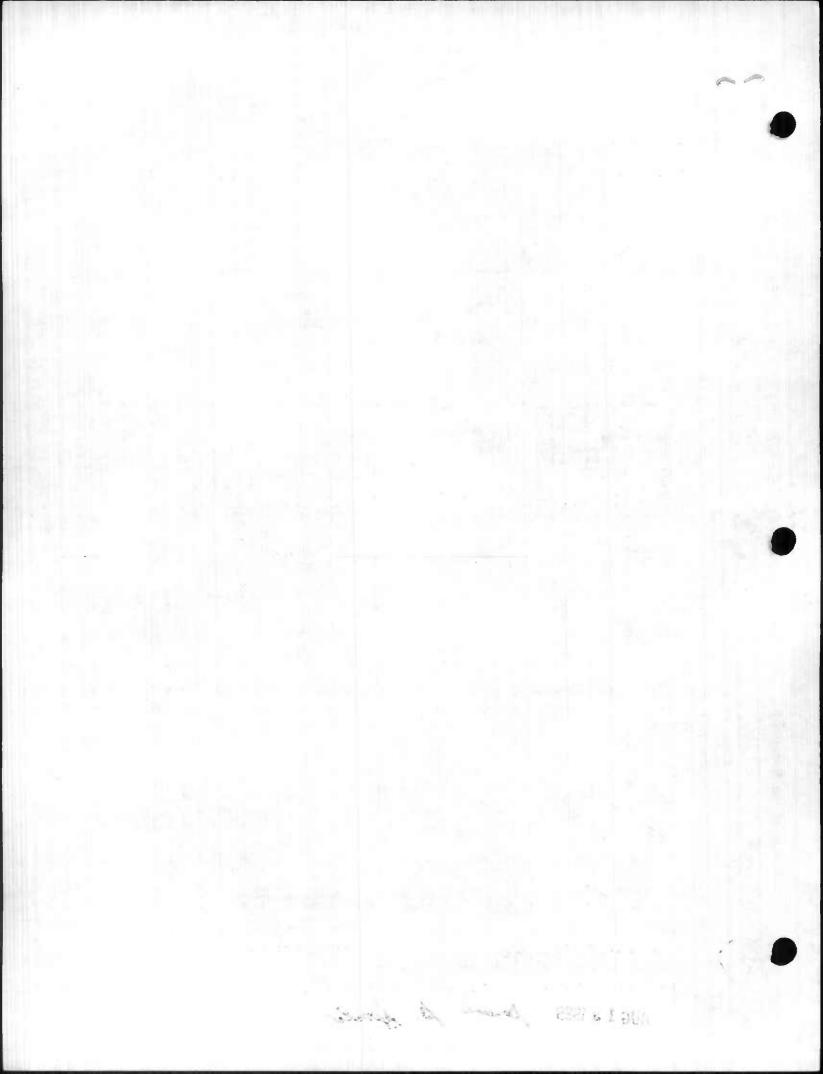
3 Suicide

29e. Certifier

2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Vaar Month **Physician** 4b. City, Town, or Location of Death TYRONE NORRIS RELERFORD 1999 0556 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ft. Washington Pr Ft. Washington Hospital Prince George's 6. Sex Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** to M 2□F Yrs. NOV. 52 PENN. 195-36-0163 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 10 2/8 XX Yes 2 No Directo PRINCE GEORGES FORT WASHINGTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23e or the Medical Examiner must be r 20744 9701 THORNVILLE DR. Funeral United States 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Nevar Married 2K Married Black Baltimore, Maryland 21215-0020 1 Yes 2 No ρ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MINE SAFETY AND HEALTH SPECIALIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 8 and Mental ROOSEVELT RELERFORD SR. DOROTHY ADAMS should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important. If New 27 is m any injury or other traum shoes. 9701 THORNVILLE DR., FORT WASHINGTON, MD 20744 BARBARA R. RELERFORD/ WIFE 20a. Method of Disposition
1 Burlal 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata OUANTICO NATIONAL CEMETERY 8-16-99 TRIANGLE, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Alexander S. Pope Funeral Homes Alexander 5. Pope Funeral Ho

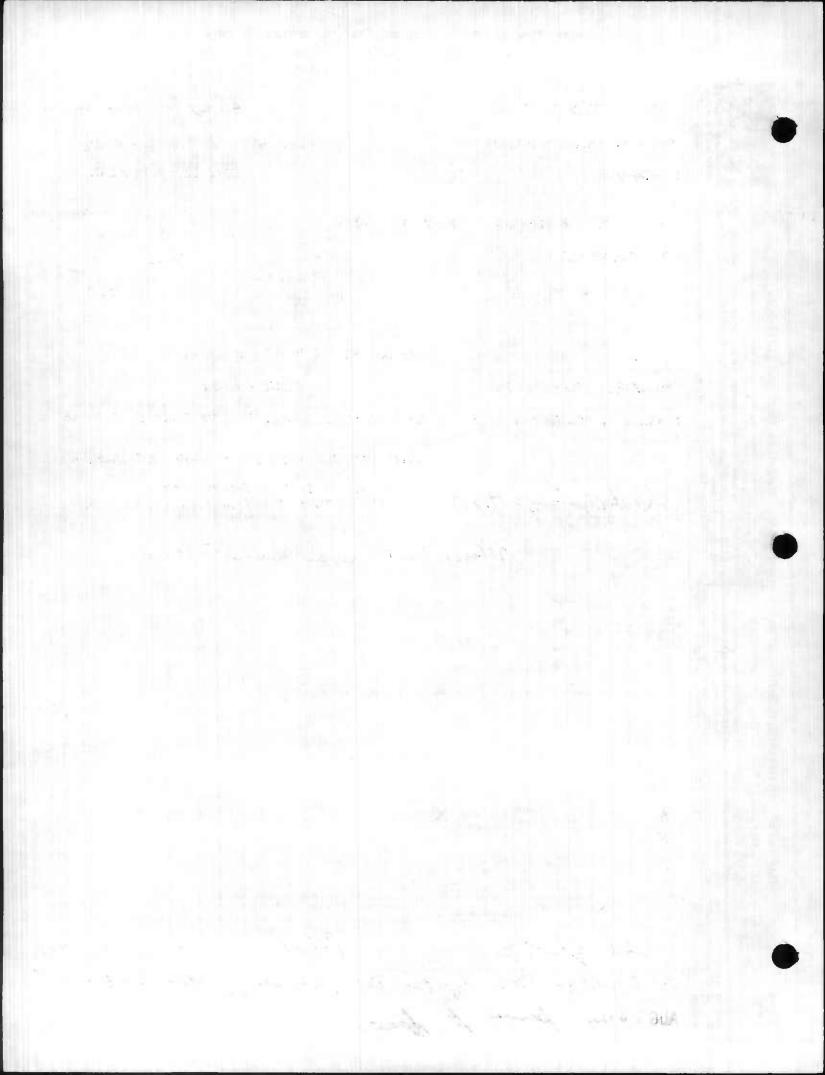
5538 Marlboro Pike/Forestvil

23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) Atherosclerotic Cardio VAScular Disense /Medical Examiner Due to (or es a consequence of) Examine dran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) physician a the burish 8 Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) 3 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. ž 1 Yes 2 No 3 Probably 4 Unknown B ۵ þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed ate has page 2 No No 1 ☐ Yas 2 ☐ No certificate 25. Was case referred to medicel Be 26. Piece of Death (Check only one) examiner?
Yes 2 No Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 1 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. injury et Work? Attending Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) atter 4 | Homicide b Furneral D 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 2 29b. Signature and titla of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ive, chewerly, Manyland 20785 Sy/vester 3001 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 3 1999

32. Registrar's Signature

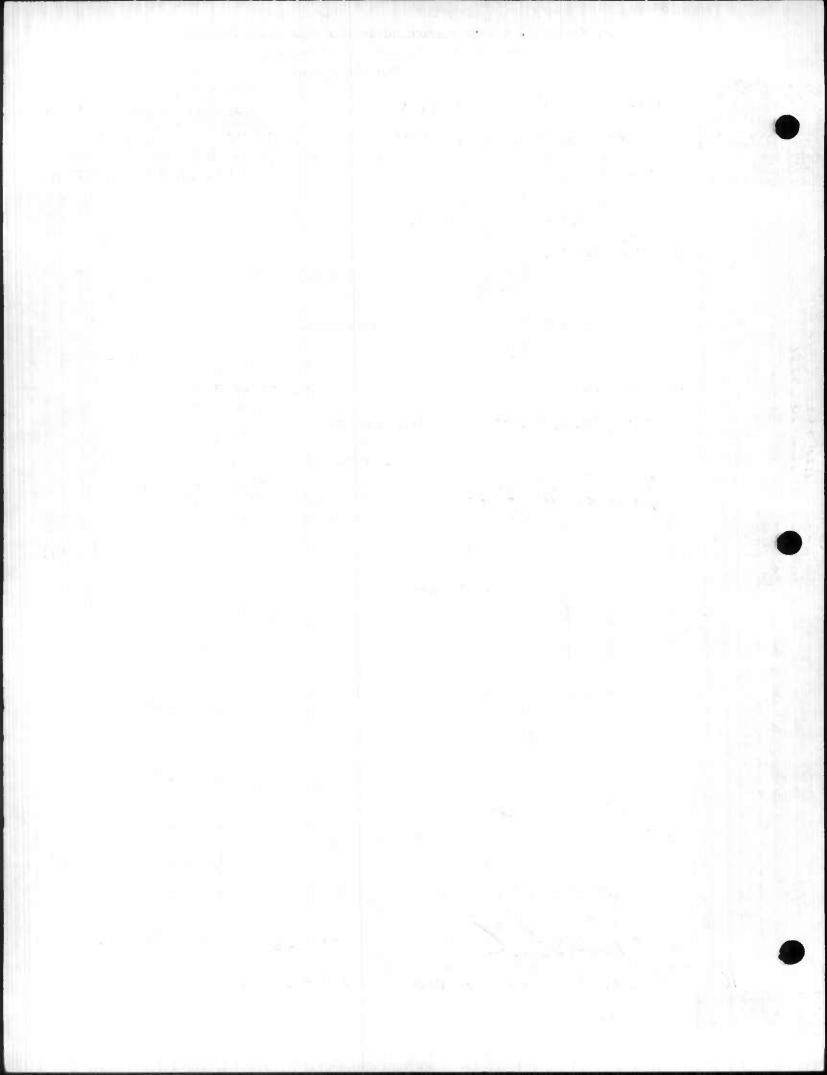


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State	e of Marylan	•	ificate of			giene 9 9 Reg. No.	27058
	Physici	an	Decedent's Neme (First, Middle, Last)	0	er-			2. Dete of De	eth	3. Time of Death
J	/Medi		Horace A		9911			Augn.	ST 17, 199	
1	Examir	er	4e. Facility Neme (If not institution, give street end PENINSULA REGIONAL		CENTER		4b. City, Town, or I SALIS			Deeth OMICO
	Funeral Director		5. Social Security Number 6. Sex 152–10–9691	7. Age (In yrs. 92		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da Sept.	th ay, Year)	9. Birthplece (Stete or Foreign Country)
Н			Usuel Residence of Decedent	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				bept.	23, 1906	Maryland
	arylan ahow	L	10e. Stete 10b. County		y, Town or Loca	ation				10d. Inside City Limits
	he Me	Director	Maryland Somerset	Wes	tover					1 Yes 2 No
	with the second		10e. Street end Number 5550 Shelltown Rd.			10f, Zip Code 21871			U.S.A.	et Country?
	Seath ms 23	Funerai		Decedent Ever In U,	S. 13. Wa		dispenic Origin? (S	pecify Yes or No		American Indian,
5-0020 72 hours after death with the Maryland natural", or thems 23s or 28s-4 show	d within 72 hours after death with the Manylan jone. r than "natural", or items 23a or 28s-f ahow the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 1 Yes	d Forces? es 2X No		res, specify Cubo ☐ Yes 2 No	dispenic Origin? (S en, Mexicen, Puert Specity:	o Rican, etc.)		White, etc. White
2-0	2 ho	ted	15. Decedent's Educetion	- 10	16e. Deceder	nt's Usuel Occup	pation during most of wor	4.5	16b. Kind of Busi	ness/industry
21	.5	Completed	(Specify only highest grade completed Elementery/Secondary (0-12) College	ea) e (1-4or 5+)	life. DC	nd of work done O NOT use retired	during most of wor d)	King		
121	e filed with al Hygiene. other than		2		Manage	r				Electric
and	d be find He od out	Be	17. Fether's Neme (First, Middle, Last) Noah S. Riggin				Cristie		, Meiden Sumeme)	
Maryland 21215-0020	and Mental	To	19e. Informent's Neme/Reletionship (Type, Print)	·	19b. Meiling	Address (Street			er, City or Town, S	tate. Zin Code)
Σ			Horace A. Riggin, Jr./s	son		Island,				,
ore	of He f fram r oth		20e. Method of Disposition 1 ◯XBuriel 2 □ Cremetion 3 □ Removel fr		lace of Disposit	tion (Neme of story or other place	ce)	Dete	20c. Location - C	ity or Town, Stete
altimore,	ment ment tant: h		4 Donetion 5 Other (Specify)		nings C	emetery	8	3-21-99	Oak Hal.	l, VA
Bal	permit. Pages 1 and 2 Department of Health of Important: If item 27 li any injury or other tra		21. Signature of Funeral Service Licensee	Pat		Neme end Addre	ross of Fecility Fo		al Home VA 234	42
	746		234. Piff 1. Enter the disease, or complications the hock, or heart failure. List only one cause of	et ceused the deeth						Approximete Intervel Between
	Physician									Onset and Deeth
	/Medical Examiner		immediete Ceuse (Finel disease or condition resulting in deeth) e.	seps	213					9 days
		Je.			r es e conseque	ence of):				
	cuted	Examiner	Sequentially list conditions	Due to (or es e consequence of):						
Ö,	e exe	EX	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury							
68760,	ficate be executed physician and is the burial-transit	edical	thet initiated events resulting in death) Lest	Due to (or	e to (or es e consequence of):					
	certific nding p use as		d							
. Box	death e atter	iciar	Pert II. Other significant conditions contributing to	a death but ant see	-141	-4-1-1	and Deat	905 814	A-h	***************************************
0	by th	Physician/M	1 6th. Other agrinicant conditions continuing to	o death but not rest	ning in the und	enying ceuse giv	en in Pen I.			ibute to the cause of death?
Ś	5 8 5	by								
Record	The law requires are has been sign page 2 should be	Completed							en autopsy prmed?	24b. Were autopsy findings aveileble prior to completion of cause of deeth?
		Con						10	Yes 20 No	1 Yes 2 No
Vita	ystcian: Th	Be	25. Wes cese referred to medical exeminer?			0"	26. Place of Dee	th (Check only	one)	
o	hys la	2	10163 22110	Inpatient 2	ER/Outpatient 28b. Time of		4 U Nursing H		dence 6 Other	
lon	ding Ph th. : After th e funeral	tion		fonth, Dey Year)	Injury	28c. Injur Wor M 1	k?` Yes 2□No	200. 00001100	now injury occurred	E
Division of Vital	X # 5 C	Certification:	3 Suicide 6 Could not be	ece of injury - At ho ilding, etc. (Specify	me, farm, stree	t, fectory, office		28f. Location (City or To		or Rural Route Number,
	Ple sile	edicai C	29a. Certifier (Check only one) Certifying Phyeician: To 2 Medical Examiner: On the end of	the best of my know e basis of exeminet nenner steted.	vledge, deeth o	ccurred et the tin stigation, in my o	ne, dete end place pinlon, deeth occu	, end due to the rred et the time,	cause(s) and menr dete end place, en	ner as eteted. d due to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signeture end title of a rtiflier	/ 10000		29c. Licens	e number	T	29d. Dete signed (Month, Day, Year)
			Fand Clin	(03	22808		8/17	199
		1	30. Name end eddress of person who completed c	ause of deeth (item	23e) (Type, Pri	int)				11
	10		Charles B. Silvia		NO	PR	mc	Salich	wy ms	51801
	Sta Registra	-	31. Date filed (Month, Day, Year) AUG 1 8 1999	2. Registrer's Signet	ture 4	lan	11		wy ms	

DHMH 16 Rev 6/95

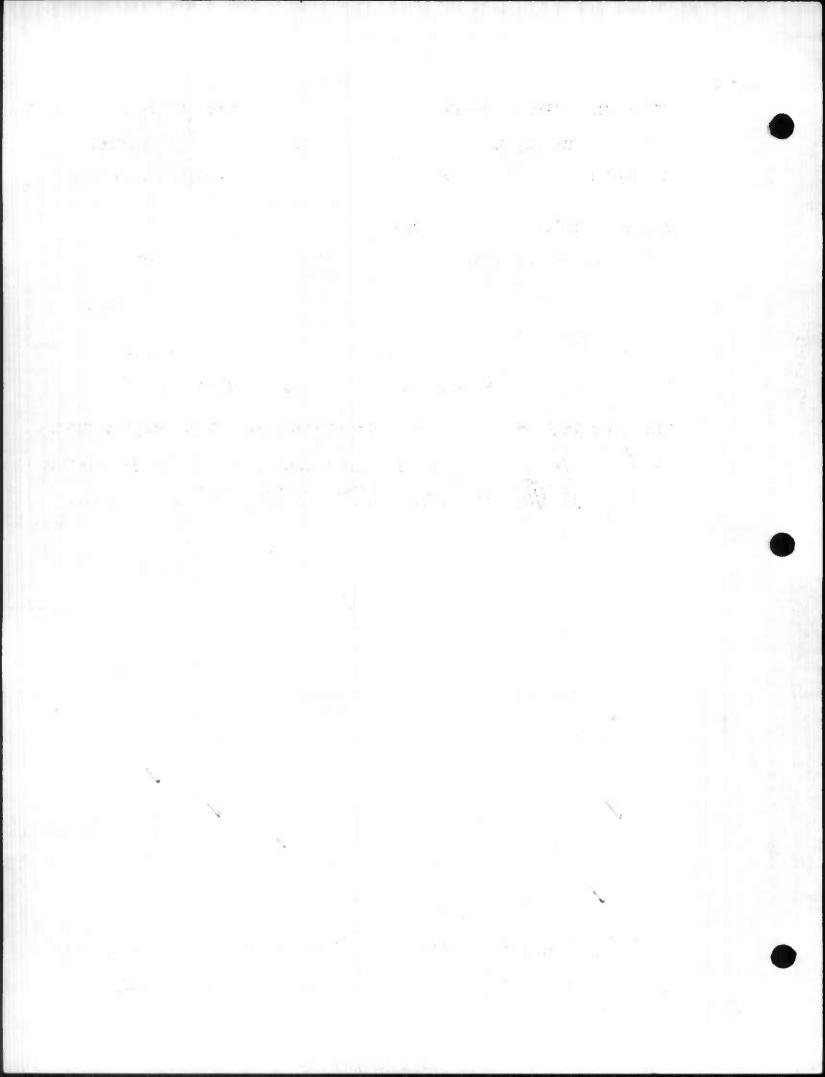
Honace A. RICKIN 152-10-5651



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					iviaryiar		tificate of		Mental Hy	Reg. No.	2	1059
н	Physic	an	Decedent's Nama (First, Middl						2. Date of Do	Day	Yaar	3. Tima of Death
	/Medi		Elizabeth I	illian E	Rennie				August		99	11:20 AM
	Exami	ner	4a. Facility Nama (If not institution	n, giva street and num	ber)			4b. City, Town, o	or Location of Dea	h 4c. County	of Death	
			920 W. Ring Fa	actory Roa	d			Joppa		Ha	arford	
	Funeral		5. Sociel Sacurity Number		7. Age (In yrs.	last birthday)	If Undar 1 Yeer	If Under 24 H	rs. 8. Data of Bi	rth Voor)	9. Birthpie	ace (Stata or Foraign
н	Director		217-12-9551	1□M 2K □F	85	Yrs.	Months Deys	Hours M	rs. 8. Data of Bi in. (Month, D NOV • 21	,1913	Marvl	and
	D		Usual Rasidance of Dacedant									
	of the state of th		10e. Stete 10b. County		10c. Cit	ty, Town or Lo	cation				10	d. Insida City Limits
	with the Maryland a or 25a-f show Lbs notified at	io.	Maryland Har:	ford		Joppa	3					1 ☐ Yas 2X No
	or 28	Director	10e. Streat and Number				10f. Zip Coda			10g. Citizan of	What Count	ry?
			920 W. Ring 1	Factory Ro	ad		210	185		USA	4	
	de d	Funeral	11. Marital Status	12. Wes Deced	deni Evar in U	.S. 13. V			(Specify Yas or N		e - Amarica	n Indian.
0		Ē	1 Naver Married 2 Marr	Armed Fore		11	Yas, specify Cub	en, Maxican, Pu	(Specify Yas or Nearto Rican, etc.)	Ble	ck, Whita, e	tc.
55	ars at	by	3 ∰Widowad 4 ☐ Divorced	If Yes Give	1	1	☐ Yes 2 🕱 No	Specify:		Specify	Whit	e
ŏ	72 hours after natural", or Its Scal Examina	b	15. Deceden	t's Education		16a. Deced	ent'a Usual Occup	ation		16b. Kind of B	usiness/Indu	atry
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Maryland 21215-0020	0 T B B	F	19a. Informant's Name/Ralations	hin (Tyne Print)		19h Mailin	n Address (Street		Rural Route Numb	er City or Town	State Zin /	Code
×	新姓年10											
	y Health Health Item 27 other tr		John W. Rennie 20a. Method of Disposition	/ Son	20h F	920 W.	Ring Fa	actory R	oad, Jop	pa, Mary 20c. Location	Land	21085
Ö	0 = 0 a		1 ₩ Buriel 2 ☐ Cremation	/3 □Ramoval from S		ematary, cren	natory or other pla	ce)	Data	200. EUGANOTI	City of Tow	ii, Stata
Ħ	tant:		4□Donation 5 □Other		Be.				8-17-99	Bel A	ir, Ma	ryland
Baltimore,	appoint in the least of the lea		21. Signature of Funarai Servida	iceptain / O		22	. Neme end Addre		. Home, P	7\		
ш	20299		Howard	(1/1)		1	50 W B	r mierar	Stroot	Pol Nir	MD 2	1014
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	icate be executed physician and s the burial-transit	Examine	Conventingly list conditions	b	Due to to	or as a conseq	uance of):					
ć	exec in an iaf-tr	Exa	Sequantially ilst conditions, if any, laading to immediata cause. Entar Undarlying Causa (Disaase or Injury		Dua to (o	n as a conseq	aarioo orj.				1	
68760,	sicia bur	edicai	Causa (Disaase or Injury that initiated evants	С	Duals (s	r as a consequ						
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P.0.	0 0 %	ysi	Part II. Other significant condition	ne contributing to dea	ith but not ras	uiting in the ur	ndarlying causa giv	en in Part I.				the cause of death?
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Records,	requires that the een signed by th hould be detach	5									Dan Was	a cubancu fin dia na
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-	aling PI After th funera		27. Mannar of Daath 1 ☑ Natural 5 ☐ Pendin	28a. Data of	Injury , Day Year)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe	how Injury occur	red	
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Division	er der de by t	tific	3 Suicida 6 Could r 4 Homicide datam	inad 288. Mace c	of injury - At ho	oma, farm, stre	eat, factory, offica			Street and Numb	er or Rural	Route Number,
	a aft a aft of in	Certification:	,	Danding	g, ato. (open)	7/			ony or ro	w, outo,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifyin	g Physician: To the b	est of my kno	wiedga, deeth	occurred et the tir	ne, data and pla	ca, and due to the	cauaa(s) and me	enner as sta	ted.
	n 24 n 24 ne Fu	edical	(Check only 2 Medical I	Examinar: On the bes	is of axamina	tion end/or inv	estigation, in my o	pinion, deeth oc	curred et the lime,	date end piace,	and dua to	he ceusa(s)
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		}	30. Name end addrass of person	who completed cause	of death /Ite~	23a) (Time !	Print)			1 -10001	13,	
			VITAY M. ARH	MANKAR		ORTH	AVF	BF7 A	TR, M	D 210	14	
	Sta	ie.	31. Dete filed (Month, Dey, Year)	32. Rec	glstrar's Signe		1	-00-1		7 10	-T	
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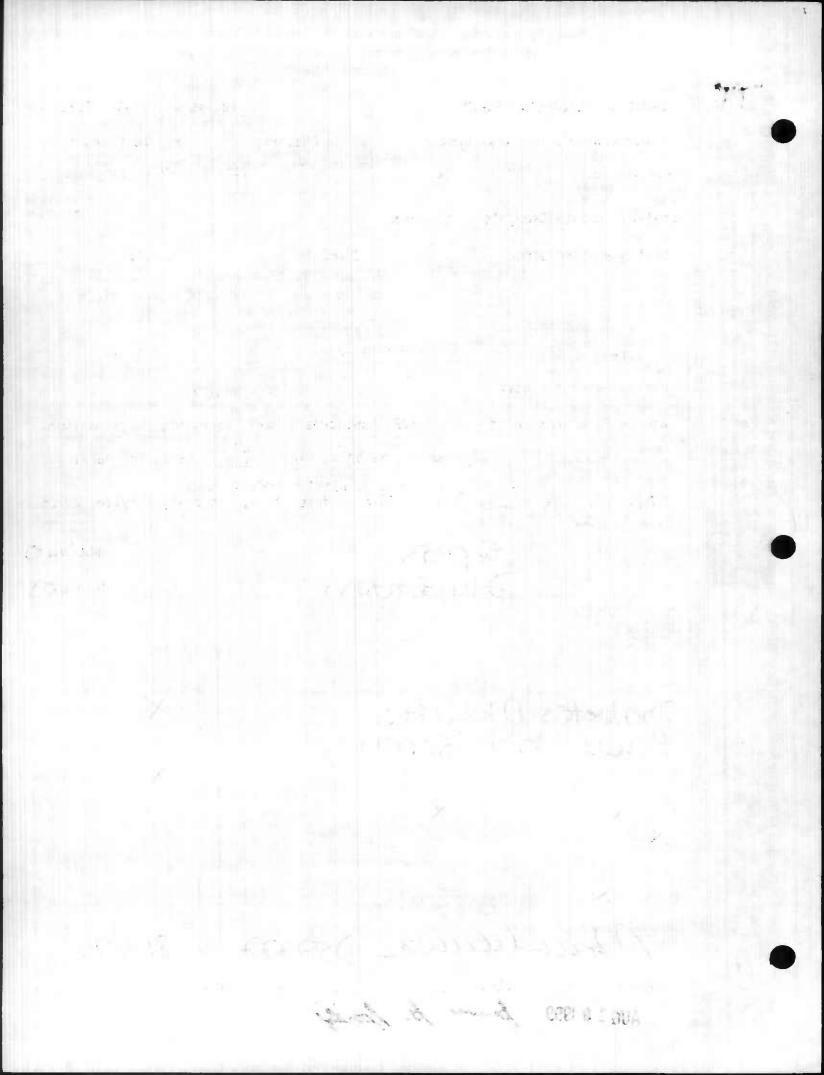
DHMH 16 Rev 6/95



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			C	ertificate of			g. No.	27060
	Physicia	_	Decedent's Name (First, Middle, Last) FRANCES ELIZABETH SMITH			2. Dete of Death Month August	Day Yea	3. Time of Death
	/Medica Examine	_	4e Fecility Name (If not Institution, give street end number)		4b. City, Town, or Lo		4c. County of De	
4	<u> </u>		Prince George's Hospital Center	M Daday 1 Vaar	Cheverly If Under 24 Hrs.		Prince G	
l	Funeral Director		5. Sociel Security Number 579-38-4076 Usual Residence of Decedent	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 25,	1931 V	lirthplace (State or Foreign Country) irginia
	/land	1	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	Se-f sh		Maryland Prince George's Landove	er				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code		10	Og. Citizen of What	Country?
	a 23a	era era	6724 Hawthorne Street 11 Marital Status 12. Wes Decedent Ever In U.S. 1	20785		acif. Vacar Na	U.S.A.	nerican Indian,
21215-0020	ol', o	by Funeral	11. Meritel Stetus 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Yeer or Detes:	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔀 No		Rican, etc.)	Black, WI	
5-0	72 ho	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupive kind of work done b. DO NOT use retired	pation during most of work	ing	16b. Kind of Busines	ss/Industry
121	ges 1 end 2 should be filed within 72 ho it of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	omemaker	a)		Privat	te
	Hygi other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, N		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than reumetic event, the Mental Color.	LOB	Robert DeWitt Scott		Colene	Bagley		
Jan	2 sho and is me			ailing Address (Street				
-	ges i end i of Health If item 27 or other tr	-	Robyne F. Lee/Daughter 672 20a. Method of Disposition 20b. Place of Dis	24 Hawthor sposition (Neme of remetory or other pla			ver, Mary	land 20785
Baltimore,	Pa Pa		4 Donation 5 Other (Specify)	Memorial	Park	08/10 1999	andover,	
Bal	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Licansee Nancy A. Percentie	J. B. JEN 7474 Land	over Road	, Landov	er. Maryl	and 20785
	1204		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failuse. List only one cause on each line.	enter the mode of dyir	ng, such as cardiec	or respiretory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Ceuse (Final					1
1	Examiner		disease or condition resulting in death) a. Use to (or as a condition to the condition of	sequenca of):				nunut 5
-	po iii	Examiner	- thydro	with				unut 5
,	and and al-trer	Exau	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a constitution)	sequence of):				
68760,	ificata be axecuted g physician and as the bunal-trensi	edical	Cause (Disease or Injury that initiated events Due to (or as a cons	sequence of):				
Box 68	eath certificata be axecuted attanding physician and for use as the bunal-trensit		resulting in death) Last					
	death e atta	Cla	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	ven in Pert I.	23b. Dld to	bacco una contribu	ute to the cause of death?
S, P.O	s that the de ned by the se detached	y Phys	Dabetes Mellitu	S		1□ Y	8 2 No 3□	Probably 4 Unknown
of Vital Records,	law requires that the death cert es been signed by the attendin 2 should be detached for use	Completed by Physician/M	Renal insufficia	ency	1	24a. Was a perform		b. Were autopsy findings available prior to completion of cause of death?
I Re	cartificate hes	E	0 0	/		1 □ Ye	s 2 No	1 Yes 2 No
/ita	ysician: s cartifica director,	D	25. Was case referred to medical axaminer?		26. Place of Deet	h (Check only on	e)	
of	2 00	0	1	ITEMIT 3LI DOA			ow injury occurred	pecify)
on	ding the After fune	20	1 Natural 5 Pending (Month, Day Year) Injur	y Wo	rk? Yes 2□No	200. Describe no	w injury occurred	
Division	or Atten efter deal Director: d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Placa of tnjury - At home, farm, building, etc. (Specify)	atreet, factory, office		28f. Location (St City or Town		Rural Route Number,
		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de control one) Certifying Physician: To the best of my knowledge, de control one one of the best of my knowledge, de control one	eath occurred at the tid Investigation, in my o	me, date and place, opinion, death occurr	and due to the ca red at the time, do	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
	Within To th comp	M	29b. Signature and title of gentling will out to Ta	29c. Licens	se number	2	9d. Date signed (Md	onth, Dey, Year)
	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	9000		01 1/	
			Meera Kanhouwa, MD, 3001 Hospital 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature	Drive, Che	verly, MD	20785		
	State • Registra	_	AUG 1 0 1999	bonk	,			

DHMH 16 Rev 6/95



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AMENDED ITEM # 9 PER MD G776 10/27/99 AH amend item 9 per G SCertificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** AUGUST 6 1999 ELLEN WILLIAMS STAUFFER 5.18PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner SLIGO CREEK NURSING HOME. TAKOMA PARK MONTGOMERY 9. Birthplece (State or Foreign Country) USA If Under 1 Year | If Under 24 Hrs. Dete of Birth (Month, Day, Year) 10/24/23 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours Min 1 □ M 2 7 F 212 22 3193 75 Yrs. Director MARYLAND Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD MONTGOMERY TAKOMA PARK Directo 10e. Street and Number 10f. Zip Code 10g. Cltizen of Whet Country? 7 is marked other than "naturel", or items 23a or traumatic event, its Medical Examiner must be a 7525 CARROLL AVENUE 20912 U.S.A. death Funeral 12. Wes Decedent Ever In U,S. Armed Forces?

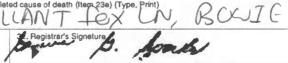
1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11. Mentel Stetus Bleck, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "naturel", or flen any injury or other traumatic event. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) TECHNICAL LIBRIARIAN PRIVATE 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be ELMER FOY WILLIAMS ELIZABETH BRIERLEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) H. BROOKE STAUFFER / SON 235 WHITMOOR TERRACE SILVER SPRING MD. 20b. Place of Disposition (Name of cametery, crametory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burlel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 8/10/99 CHESAPEAKE CREMATORY BELTSVILLE 22. Name end Address of Fecility POPE 21. Signature of Funeral Service Licensee FUNERAL HOME, 11315 lockwood DRIVE SILVER SPRING MD. 20904 mds Pm11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel years disease or condition resulting in death) arunor Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) that the death certificate be exe P.O. Box 68760. Physician/Medical Due to (or as e consequence of) as USB 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. ed by th 12 Yee 2 No 3 Probably 4 Unknown signed be det Division of Vital Records. Ag 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed page 2 s 2 No 1 ☐ Yes 1 □ Yes 2 □ No certificate or Attending Physicien: director, 26. Place of Deeth (Check only one) Be 25. Wes case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 0 1 Tyes 25 No 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending 1 Naturel after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours a Hospital 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier (Check only one) edicai complately To the Vithin 2 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Dete filed (Month, Day, Year) AUG 1 0 1999

30. Name end



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State of Maryland / Department of Health and Mental Hygiene 2 7 0 6 2

				C	Certificate o	f Death		Reg. No.		
П		1. Decedent's Neme (First, Middle	, Last)			17.	2. Dete of D	eeth	Vone	3. Time of Deeth
н	Physician /Modical	EUGENE WILL	AM SMITH				August	t 07 1	Year 999	10:26 AM
4	/Medical Examiner	4e Facility Neme (If not Institution	give street and number)			4b. City, To	wn, or Location of Dee			
4		Holy Cross Ho	spital			Silve	er Spring	Montg	omerv	,
	Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birtho	Months Dev	er If Under:	24 Hrs. 8. Dete of B (Month, D	irth		place (State or Foreign
	Director	220-32-5998	10XM 2□ F	63 Yr	s. Months Do	710013	Augus		Mar	yland
	2 >	Usuet Residence of Decedent 10e. Stete 10b. County		10c. City, Town o	ar I coation					10d. Inside City Limits
	show stat									1 X Yes 2 □ No
	or 28s-1 s be notified Director	Maryland Prince	e George's	Capito	1 Heights			10g. Citizen of V	Mhat Cau	
	Dir Dir	GEOO lonlin	*****							ntry t
	s 23	6508 Joplin S	12. Wes Decedent Ev	var in II C	207		aln? (Specify Vee or N	U.S.		can Indien,
	r items 234	11. Meritel Stetus 1 □ Never Merried 2 🕱 Marri	Armed Forces?		If Yes, specify C	uban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	Blee	ck, White,	
)20	s 1 and 2 should be filed within 72 hours efter death with the Meryland (Health and Mental Hygiene. If Health and Mental Hygiene. It is marked other than "natural", or items 23s or 28=4 show other traumatic event, the Medical Evantive must be notified at To Be Completed by Funeral Director	3 □ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:		1□Yes 2⊠N	o Specify:		Specify	/: B1	ack
21215-0020	thurs thurs	15. Decedent	- 10/11/2/1-1-1	16a. D	ecedent's Usuel Occ	upation		16b. Kind of B	usiness/in	dustry
215	led within 72 ho tygiene. Wr than "natura nt, the Medical Completed	(Specify only highes	t grede completed)	(()	Give kind of work do de. DO NOT use ret	ne during most	of working			
21	J with the piene	Elementery/Secondary (0-12) 8th	College (1-4or 5+	,	Chef			Govern	ment	
P	be filed tal Hygi d other event, t	17. Father's Neme (First, Middle,	.ast)			18. Mothe	r's Neme (First, Middl	e, Maiden Suman	ne)	
/a	Menta	William Auth	or Smith			Mar	garet Bro	wn		
Maryland	2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the To Be Comp	19e. informent's Name/Reletions	ip (Type, Print)	19b. N	Aeiling Address (Stre	et end Numbe	er or Rural Route Num	ber, City or Town,	Stete, Zip	Code)
	1 end 2 Heelth em 27 is	Arlean C. Smit	h/Wife	650	8 Joplin	Street	, Capitol	Heights,	MD	20743
Baltimore,	parmit. Peges 1 end Department of Heelth Important: If item 27 any Injury or other tr once.	20a. Method of Disposition		20b. Place of D	isposition (Neme of crematory or other p	olece)	08/13	20c. Location -	City or To	own, Stete
E	parmit. Peges Department of t important: if ite any injury or o	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (St			ection Ce		1999	Clinto	n. Ma	aryland
alti	parmit. Departmine processing in the posts and the posts a	21. Signeture of Funerel Service I	icensee				UNERAL HON			
m	Page 1	Na	1 P T							J 2070F
		23a. Pert1. Enter the discount of shock, or heert feilure. List	complications that caused to	he death. Do not	enter the mode of	lying, such es	Road, Lando cardiac or respiretory	errest, Mai	ylan	Approximete
J	Physician	snock, or neert fellure. List	only one ceuse on eech line							triterval Between Onset and Death
	/Medical	Immediete Ceuse (Finel diseese or condition	Sensis	in Shock	k				1	2 days
	Examiner	resulting In death)	е	ue to (or es e co						z days
	ž ž			s Melli						10 years
	the death certificate be executed y the ettending physicien end sched for use as the bunal-transit hysician/Medical Examiner	Sequentielly list conditions,	D	ue to (or es e co	nsequence of):					
0	e exe	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	End sta	ge rena	l disease				1	5 years
68760,	entificate be ling physicie e es the bur	that initieted events resulting in deeth) Lest	G	ue to (or es e cor						
9 x	ing p		Periphe	ral vase	cular Disc	ease				5 years
Bo	tendi or us		d							1
	d by the ettend eteched for us	Pert II. Other significant conditio	ns contributing to death but	not resulting in t	he underlying cause	given In Pert t	. 23b. Die	d tobacco use co	ntribute t	to the cause of death?
P.0	ed by the deteched						10	Yes 2 No	3 Pro	bably 4XXUnknown
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Records,	The law require sate hes been signed to pege 2 should the Completed							s an eutopsy formed?	6/	/ere eutopsy findings veliable prior to ompletion of cause
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of	× 50 5	1 ☐ Yes 2 ◯ No	Hospitel: 1 🔀 Inpatient	2 ER/Outp	etient 3L DOA		irsing Home 5 ☐ Re		-	(fy)
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Division	tal or Attending P is effer death. In Director: After t led in by the funers Certification:	2 Accident Investig	ation		M 1	☐ Yes 2☐				
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	n 24 hour no Europies y files of the edical	29a. Certifier 1 Certifying (Check only 2 Medical I	Physician: To the best of examinar: On the basis of e							
	To the Hospital or Attending is within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral Medical Certification:		and menner stete	ed.						
	ST S	29b. Signeture end title of certifie	-			ense number		29d. Dete signe		
			sau -		U	21611		August	/, 1	. 399
	(4)	30. Neme and address of person								
	U				t Avenue,	Kensi	nton, Mary	land 208	95	
	State	31. Dete filed (Month, Dey, Year)	33 Registrer	's Signeture	1					
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State of Maryland / Department of Health and Mental Hygiene

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			C	ertificate o	f Death	P	leg. No.	7 6	1000
	1. Decedent's Name (First, Middle, Last)				2. Date of Dee Month	th Dev	Year	3. Time of Death
Physician /Medical	Edwin Lee	Sellers,	Sr.				5, 1999		4:16 am
Examiner	4a Facility Name (If not institution, give	street end number)			4b. City, Town, or L		4c. County		
	Montgomery Genera	1 Hospital			Olney		Mont	gome	ry
Funeral	5. Social Security Number 6. Se	7. Age (In	yrs. last birtho	Months Dev		8. Date of Birth (Month, De)	Year)	9. Birthple	ece (Stete or Foreig
Director	5/8-16-4411	JM 2□ F	77 Yn			April 11	, 1922	Wash	ington, l
pu a	Usual Residenca of Decedent 10a. Stete 10b. County	10	c. City, Town o	r Location				10	od. Inside City Limit
lanylar show ed at	2-4-7-6								1 Yes 2 □ N
the Maryla 28a-1 shor noursed at	Maryland Prince G	eorge s	Bo	wie 10f. Zip Code			10g. Citizen of V	/het Count	nv?
with with	11916 Galaxy Lan	0			20715		U.S.A		.,.
5-0020 72 hours after death with the Maryland natural, or items 23s or 28s-1 show licel Examine must be notified at steel by Funeral Director	11. Meritel Status	12. Was Decedent Ever	in U.S.			ecify Yes or No-		a - America	an Indian,
har dea ritems	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No	.,,,,,,,		f Hispanic Origin? (Spuban, Mexican, Puerto	Rican, etc.)	Blec	k, White, e	itc.
D20 urs aff	3 ☐ Widowed 4 ☒Divorced	If Yes, Give Yeer or Dates: WW	TT	1□Yes 2XIN	o Specify:		Specify	Wh	ite
5-0020 72 hours at natural; or dical Even	15. Decedent's Edu	cation	160 D	ecedent's Usual Occ	upetion		16b. Kind of Bu	siness/ind	ustry
I 21215-0 led within 72 ho byglene. For than "neture II, the Medical.	(Specify only highest great Elementery/Secondary (0-12)	e completed) College (1-4or 5+)	(C	ive kind of work dor fe. DO NOT use reti	ne during most of work ired)	ang			
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altimore, mit. Pages 1 an partment of Heal portant: If fam 2 y Injury or other	20e. Method of Disposition 1 X Buriel 2 Cremetion 3 DR		Ob. Place of D cemetery,	isposition (Name of cremetory or other p	lece)	Dete	20c. Location -	City or Tov	vn, State
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Examiner	resulting in deeth)	Due	to (or es e co	nsequence of):	bacte				-
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Sian Sian Suriel	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypo	Xemi	c Despi	Ratory	tack	10		
68760, ficate be explorate by physician as the burial edical E	thet initieted events resulting in death) Lest	Due	to (or as a cor	sequenca of					
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death cert death cert e attendin e attendin ed for use									
the de y the control of the de	Pert II. Other significant conditions co		0		given in Part I.		1/		the cause of deat
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Vision Attending or death. Ector: Afte by the fune	2 Accident Investigation 3 Suicide 6 Could not be	28e. Plece of Injury -	At home form			28f Location (5	Street end Numb	er or Rura	l Route Number
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Divisi To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completaly filled in by the	29a. Certifier Certifying Phy	sician: To the best of m	v knowledne o	eath occurred at the	time date and piece	end due to the	rausa(s) and me	nner as st	eted
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within 2 To the comple	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signe	d (Month, L	Day, Year)
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(0)	30. Nerve end eddress of person who o	on pleted cause of death	/ltem 22e) (T-		- / - /		//	- /	
8	COLLEGE OF THE COLLEG	CAS / C. P. C.	MO (1)	18/11/80	nce Ph. 4	o De	0 0/10	M	sayland
State	31. Dete filed (Month, Dey, Year)	32. Registrar's			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7		7	7,710
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month ISMEE, EEL Mohammed SHAH 8:20 PM August /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY Cross HOSPITAL SILVER SPRING MONTGOMERY If Under 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dele of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15€M 2□ F Hours Yrs Director None 20 8-9-99 Maryland Usual Residence of Decedent the Maryland 10e State 10b. Counfy 10c. City, Town or Location 28a-f show 10d. Inside City Limits 1 Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 2100 Shorefield Rd. 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after Never Married 2 ☐ Married 1 Yes No If Yes, Give Year or Dates: 21215-0020 "naturel", or 1 ☐ Yes 2 ☐ No Specify. Indian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None None 0 other t Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Kalim Mohammed Shah Sharon Achong Shah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) if item 27 is n Kalim Mohammed Shah 2100 Shorefield Rd, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 8-10-99 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) George Washington 22. Name and Address of Fecility UNIVERSAL MORTUARY INC. Funeral Service Licenses art1. Enter the disease, or complications that cause it in deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, nock, or heart failure. List only one cause on each line 411 Kennedy St, N.W., Washington, D.C. Interval Between Physician /Medical Onset and Death Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Examiner 20 weeks certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medicai Due to (or as a consequence of) P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 XNo 3 Probably 4 Unknown Records. g Completed 24b. Were autopsy findings available prior to 24a. Was an eutopsy completion of cause of death? The 1 Yes 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel 2 Accident death. 1 Yes 2 No 24 hours after deal Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - Al home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 determined 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) end manner as steled.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier completely (Check only one) To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45369 August 9, 1999 auso of death (Nem 238) (Type, Print) ALAN K. GOLDBERG, MD Road SILVER SPRING, MD 20910 32. Registrar's Signature State Registrar

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State of Maryland	/ Department	of Health and Men	ital Hygien
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	Physic /Medi		MARY R. SELLMA	N						ST 9,	1999	7:20 A.M.
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н	Funeral		5. Social Sacurity Number 6. S	9X 7. □M 2MŽF	Aga (In yrs. Ia 84		Months Days	Hours Mi	n. (Month,	Day, Year)	9. Birt	hplaca (Stata or Foreign buntry) HINGTON, DC
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	yland		10a. Stata 10b. County		10c. City,	, Town or Locat	ion					t 0d. Insida City Limits
	r 28a-f show	ctor	MARYLAND MONTGOME	ERY COUNT	ry I	CAKOMA E	PARK					1XXYas 2 □ No
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	f Health tem 27 other tr		JAMES A. SELLMAN, 20a. Mathod of Disposition	JR., 50	20b. Pla	ace of Dispositi	on (Nama of	ILL DRI	Data		ocation - City or	
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altimore,	permit. Pa Departmen Important: any Injury ance.		21. Signeture of Funeral Service Licen		FUR		OLN CEMI ame and Addre		0/12/9	DIG	LIVIWOOD	, FIARTLAND
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-	TO 0 12	Physician/Me	Part II. Other significant conditions of	ontributing to deat	h but not rasul	Iting in the unde	arlying causa giv	van in Part I.	23b. D	ld tobacco	usa contribute	to the cause of death?
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no		tion	1 Matural 5 ☐ Panding	(Month,	Day Year)	Injury	28c. Inju	rk? Yas 2 □ No	200. 540011	o trove inju	ary cocurred	
Division	Attending ir death. ector: Alse by the fune	fica	3 Suicide 6 Could not be	28a. Placa of	Injury - At hor	ma, farm, straat	, fectory, office					urel Routa Number,
á	5 등 등 6	Certification:	4 ☐ Homicida	building,	, atc. (Specify))			City or	Town, Stati	a <i>)</i>	
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	(10)		30. Nama and addrass of person who of A L JAWAD WA	complated causa	of death (Itam	23a) (Typa, Pri	nt)	V= Si	to 100	Roc	KVILLE	M2 20852
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State Registrar

31. Data filad (Month, Day, Yaar)
AUG 1 1 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Dete of Death **Physician** Month Year Susie Strange 08 80 99 6:50am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thomas More Nsq/Reb Center Hyattsville, Md Prince George If Linder 1 Veer 9. Birthplace (State or Foreign T904 Nelson Co., VA 5. Social Security Number 7. Age (In yrs. last birthday) f Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 578-74-6963M 95 Yrs Director Co., VA Usual Residence of Decedent the Meryland 10a. State 10h County 10c. City, Town or Location worle ! 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at None D.C. Washington 1 Yes 2 No Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? U.S.A. 20010 3620 - 11th Street, N.W. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritet Stetus permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item eny Injury or other traumatic event. In Medical Fermin Bleck, White, etc. 1 ☐ Yes 2 ② No If Yas, Give 1 Naver Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: **Black** Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Own Home Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 6 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Fannie Hill Charlie Strange 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 113 Christine Strange/Daughter 22922 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20e. Method of Disposition 20c. Location - City or Town, Stete /14/99 1 20Buriel 2 Cremetion 3 Removel from State Clinton, orest Hills Mem. Cem 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Henry Co., Inc., 492 Washington, DC 20019 Burroughstan & 21. Signeture of Funeral Service Licensee any ratt 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final /Medical disease or condition resulting in death) Examiner Examiner sician and burial-transit death certificate be axacuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician as the burial P.O. Box 68760. Physician/Medical Due to (or es a consequence of): ed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yaa 2 No 3 Probably 4 Unknown Records. þ been sig 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes en autopsy 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 452 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28c. Injury at Work? After 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of trijury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c 1 icense number 29d. Dete signed (Month, Day, Year) August 10, 1999

State Registrar

Saiid Meer Zonozi, M.D. 31. Date filed (Month, Dey, Year) AUG 1 1 1999

30. Name end address of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

1328

Washington,

Southern Avenue, S.E. Suite 307

DC 20032

2011 1 20A

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			Certificate of Death	Reg. No.	2/06/
		1. Decedent's Name (First, Middla, Last)		2 Date of Death	3. Tima of Deeth
	Physician /Medical	Ethel Simms		August 3, 1999	10:00PM
	Examiner	4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or L		lh
20		7006 Westchester Drive	Camp Spri	ng Prince Ge	orge
	Funeral Director	5. Social Security Number 6. Sax 1 M 2 1 F 7. Aga (In yrs. last to 5 1 7 3 0 3 1 7 9	birthday) If Undar 1 Yaar II Undar 24 Hrs. Months Days Hours Min.	(Month, Day, Year) Co	thplaca (Stata or Foraign puntry) hington, D.C
-	2 ,	Usual Residence of Dacedani			land to the On I have
	aryan de hoy		own or Location		10d. Inside City Limits 1) Yes 2 □ No
	or 28a-fel be notified Director		Spring		**
4	Direction of the second	10e. Street and Number	10f. Zip Coda	10g. Citizen of What Co	ountry?
4	23a	7006 Westchester Drive	20748	U.S.A.	atom to disa
21215-0020	o within 7.2 hours after death with the maryland jees. Then 'natural', or items 23s or 28s-f show the Medical Examinat must be notified at ompleted by Funeral Director	11. Marital Status 1 Navar Married 2 Married 1 Navar Married 2 Married 3 Not Married 4 Divorced 12. Was Decedant Evar in U,S. Armed Forcas? 1 Navar Married 2 Married It Yas, Giva Yaar or Dalas:	13. Wes Decedent of Hispenic Origin? (Spif Yas, specify Cuban, Maxican, Puarto		
5-0	ygiene. or than "naturality, he weden!	15. Decedant's Education (Spacify only highest grade completed)	la. Decedant's Usual Occupation	16b. Kind of Businass	/Industry
21		Elementery/Secondary (0-12) Collega (1-4or 5+)	(Giva kind of work dona during most of work lifa. DO NOT use retired)		
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yla V	and Mental on a marked o aumatic eve		Claudia		
= 0	4 = 5 = 6		9b. Meiling Addrass (Street end Number or Rui		
	other tr		006 Westchester Drive		
Baltimore,	200	4 Donation 5 Other (Specify)	of Disposition (Nama of tary, crematory or other place) ony Mem. Park Cem.	Dala 20c. Location - City or 8-10-99 Landover,	
Ball	Department of Important: If any injury or	21. Signature of Enfant Service Afcenses	22. Nama and Addrass of Facility S 1601 Kenilworth Av	locum Funeral Serv enue,NE Wash,DC 20	
		23a. Part1. Enter the disease, or compilcations that caused the death. Deshock, or heart failure. List only one cause on each line.			Approximete Interval Batween
	hysician /Medical xaminer	Immediate Cause (Final disaasa or condition rasulting in daalh)	ve heart far	lue	Onset end Deeth
3	n and ial-transit	b. atrial	a consequence of):		
	usein berinnale be associed e attending physician and by for use es the bunal-transit sician/Medical Examir	Sequantially list conditions, if any, laading to immadiata cause. Enler Undarfying Causa (Disaasa or Injury	a dondequence of):		
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587	at the used beginned by the attending physicial etached for use as the bur Physician/Medical		a consequance of):		
×	use esu	d			
Вох	attendir I for use clan/A				
o i	the shed	Pert II. Other algnificant conditions contributing to death but not resulting	In the undarlying cause givan in Part I.	23b. Did tobacco usa contribute	s to the cause of death?
ecords, P.O	ed by the detached			1 □ Yss 2 No 3 □ P	robably 4 Unknown
Vital Records,	been signed be stated by Pleted by Pl			24e. Wes an autopsy 24b.	Were autopsy tindings
Ö	ate has been a page 2 should			performed?	available prior to completion of cause
360	has be 2 s				of death?
<u>m</u>	C pag			1 ☐ Yes 2 No	1 ☐ Yas 2 ☐ No
	certificate he rector, page	25. Was casa rafarred to medical axaminar? Hospital:	Other	Ih (Check only one)	
of Vita	His DT	1 Inpatient 2 ER/	Outpatient 3L DOA 4L Nursing H	oma 5 Rasidance 8 Othar (Spe 28d, Dascribe how injury occurred	ecify)
uo a	After une une	Natural 5 Panding (Month, Day Year)	o. Tima of tnjury at Work? M 1 Yes 2 No	200. Dascribe now injury occurred	
Division	as after death. at Director: After to death of the funeral control of the function of the functi	2 Accidant invastigation 3 Sulcida 6 Could not be		28f. Location (Straat and Number or R	hural Bouta Number
N S	after after d in by	4 Homicida dalermined 28a. Place of Injury - At homa, building, atc. (Specify)	ram, straat, ractory, onice	City or Town, Stata)	ararriodia redibar,
<u>ا</u>	C IIIed	200 00-170-1			
3	within 24 hours after death. To the Funeral Director: After completely filled in by the fune. Medical Certification	29a. Certifiar (Check only one) 1 Medical Examinar: On the basis of axamination and manner stated.			
- 4	The mple	29b. Signeture end title of certifier	29c. Licansa number	29d. Dale signed (Mon	th Day Year)
4	1 8 4	N MACICO BULLIOLEAN	LAN TONS	336 01.11	00
	(m)	mounty summer.	· 6000000	260 0191	79
		30. Nema and address of person who completed cause of daeth (Item 23e) Marad Bur Welfe b [i	OY Ola Brauch	Ave Temple!	Hills ME
	State Registrar	31. Data filad (Month, Day, ¥ear) 32. Begistrar's Signature	4 1.5.		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2 Date of Death Month Dicca Mar August 1999 00 12 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name of not institution, give street and number) Balhmore Hopkins tuspital Johns 8. Date of Birth (Month, Dey, Year) If Undar 1 Year | If Under 24 Hrs. 6 Sax 5. Social Security Number 7. Age (In yrs. last birthdey) 1□ M 2⊠ F Days Hours Yrs. 175-30-8482 59 4, 1939 Pennsylvania Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 STNo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4017 Sharilyn Dr. 21009 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Co-Owner Concrete 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middla, Last) Russell McDowell Huffman Mary Dorothy Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joe Sicca / Son 4017 Sharilyn Dr., Abingdon, Maryland 21009 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 8-16-99 Baltimore, Maryland 22. Nama and Address of Facility McComas Funeral Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Artery Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No

Physician /Medical **Examiner**

signed by t

certificate

After this

efter death.

24 hours e

To the within 2

Hospital or Attending Physician:

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Completed

Certification: To

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Department of Health ar Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

10a State

Funeral

Director

r 28a-f show

Directo

Funeral

by

Completed

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. Interfer or items 23s or 28s-f show int. If Item 27 is marked other than "naturel", or items 23s or 28s-f show

I Hygiene.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

7 is merked other than "naturel", or items 23a or traumetic event, the Medical Examinor must be a

Examiner Physician/Medicai USB

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No

5. Was case referred to medical				26. Place of Death	(Check only one)	
axaminar? 1 Yes 2 No	Hospital: 1 Impatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)
7. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c.	Injury at Work?	28d. Describe how in	jury occurred

investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29b. Signature and title of ogriffier

4 Homicide

29a. Certifier

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

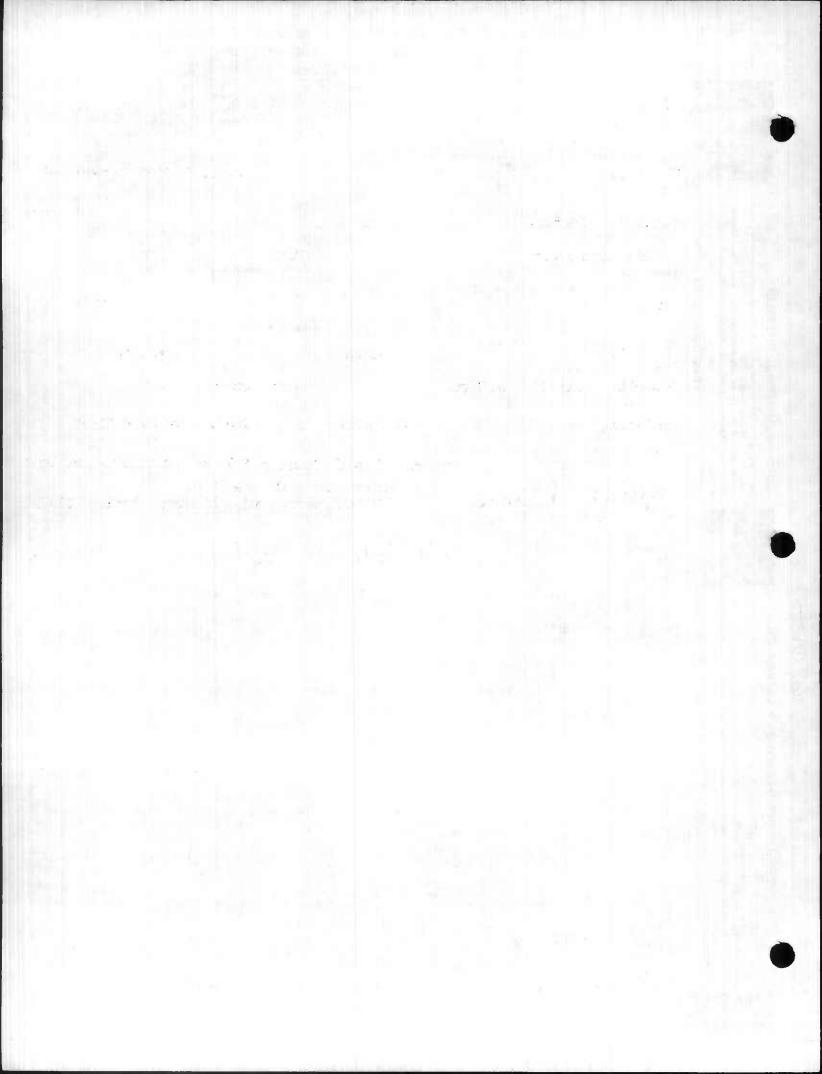
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licanse number

RES-000

address of person who completed cause of death (Item 23a) (Type, Print)

600 North Water Street, Baltimore, MD 618 Blalock 32. Registrar's Signature

State Registrar



99-4669-033 CJMary Louise To

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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lson		Otato of Ma	Ce	Certificate of Death Reg. No.					7069	
Physician /Medical Examiner Funeral Director	1. Decedent's Neme (First, Middle, Last) Mary L. Tolson				2. Date of De Month August	Day	Year	3. Time of Death 10:05 AM.		
	4a Facility Nama (If not institution,					or Location of Deat	n of Death 4c. County of Death			
		Prince George's Hospital						-		
	5. Sociel Security Number 212–76–8922 Usual Rasidence of Decedent	3. Sex 7. Age 1	Months Days Hours			lin. (Month, Da		Year) 9. Birthplaca (State or Foreign Country) Country) 9. Birthplaca (State or Foreign D.C		
	10a. Stete 10b. County	s	10c. City, Town or LaPlata					10d.	fnside City Limits	
	10e. Street and Number			10f. Zip Code				What Country	?	
23 w		418 Nanjemoy Drive					USA			
020 um after death v air, or hems 23s Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decadent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yas 2 ☒ No Specify:			or No- 14. Race - American Indian, Black, White, etc. Specify: Black			
72 ho		15. Decedent's Education (Specify only highest grade completed)			6a. Decedent's Usual Occupation			16b. Kind of Business/Industry		
Maryland 21215-0020 2 should be list within 72 hours at this and Mental Hypiene. 7 is marked other than "natural", or traumedic event, the Medical Exam To Be Completed by I	Elementery/Secondary (0-12)	Elementery/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Clerk					
		est)	50	ock clei		Neme (First, Middle	Targe			
	m l				Frances Coa					
	19a. Informant's Neme/Relationsh	p (Type, Print)	19b. Mail	ing Address (Stre			ber, City or Town, State, Zip Code)			
	Geraldine Tolso	n- Sister	6720	Central	Hills T	errace La	ndover.	MD 207	85	
Baltimore, permit. Pages 1 ar Department of Hear Important. If Item; any Injury or other since.	Geraldine Tolson- Sister 6720 Central Hills Terrace Landover, MD 20785									
	21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Adams Funeral Home Aquasco, Maryland 20608									
Physician	23a. Pert1. Enter the disease, or o shock, or heart failere. List o	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate thierval Between Onset and Death								
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):							
60, be executed ician and burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	b. — Due to (or as a consequanca of):							
f Vital Records, P.O. Box 68760 yalcian: The law requires that the death certificate be s certificate has been signed by the attending physicial director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	rasulting in death) Last		c							
	28	a								
	Part tt. Other algnificant conditions contributing to death but not resulting is			g in tha underlying cause given in Part I.			Yes 2 No		ne cause of death?	
						24a. Was en eutopsy performed?		b. Were autopsy findings eveilable prior to completion of cause of death?		
	E C					18	Yes 2□No	10	′as 2□ No	
	25. Was case referred to medical		26. Place of Deeth (Check only one)							
	1 1 Yes 2 No	Hospital: 1 ☐ Inpatien	1 Inpatient 2 LAER/Outpatient 3 IDOA 4 Invising Home 5 In Residence 8 In Other (Specify)							
	27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation	(Month, Dey	28a. Dete of finjury (Month, Dey Year) 8 1 96 0947 AM 28c. tnjury at Work? 1 1 Yes 2 1 No Driver O				FCDP/IMPACTUITS			
Division Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	3 Suicide 6 Could no determine	t be ed 28e. Placa of Inju building, etc.	28e. Placa of Injuly - At home, farm, street, factory, office building, etc. (Specify)				281. Location (Street and Number or Rural Route Number, City or Town, Stete) LAPUATARD HRTS CHARLES CO. IND			
he Hospi in 24 hou he Funer pletely fill	29a. Certifier 1 Certifying (Check only one) 2 Madical E	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2. Madical Examiner: On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.							ed. e cause(s)	
0205	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month, Da	V. Year)	

of person who completed cause of deeth (Item 23s) (Type, Print)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

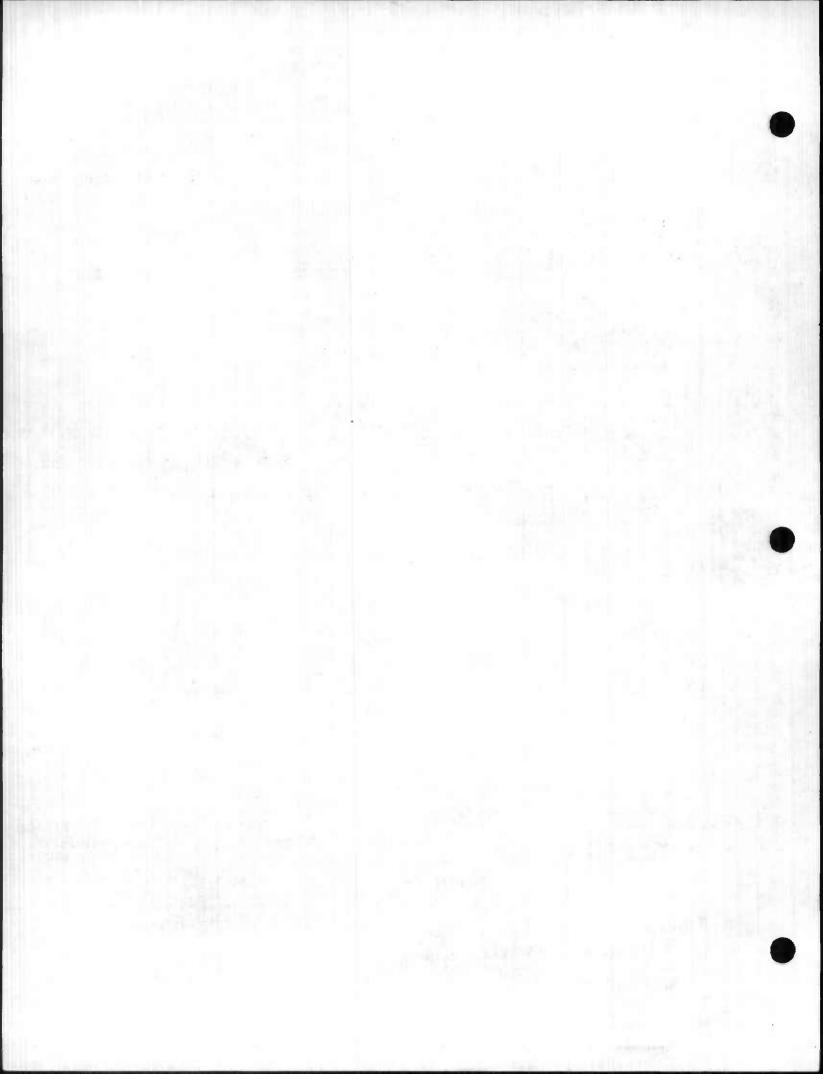
Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

O.C.M.E.

August 12, 1999

desoys KORALII Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		C	ertificate of	Death	Reg	. No.	2/0	HU		
Dhuaisia	1. Decedent's Name (First, Middle, Last)		2. Dete of D Month			Death 3. Tim				
Physiciar /Medica	('alwin 'lurner				August	8]	1999 7:	50PM		
Examine	4a Facility Neme (If not institution, give street end number	*		4b. City, Town, or I		4c. County				
	Washington Adventist H	*		Takoma l			ntgomery			
Funeral Director	245-09-1495 ¹\\ 1\\ \overline{M} 2□ F	Age (In yrs. last birthda 94 Yrs.	Months Day		8. Dete of Birth (Month, Day,) Sept. 26	1904	9. Birthplace (State Country) Louisian	100		
020 urs after death with the Maryland all, or Nems 23e or 28s-f show Examinar must be notified at by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d Inside	City Limits		
			Mt. Raini	0.36				es 2 No		
	10e. Street and Number					10g. Citizen of What Country?				
						Unite	ed States			
	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Detes	1 ☐ Yes 2 ☐ No		 13. Wes Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify: 			No- 14. Race - American Indian, Bleck, White etc. African Specify: American			
72 hours	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Oth College (1-40	16a. Dec	cedent's Usuet Occi	upation e during most of wor	king 16	b. Kind of Bu	siness/Industry			
within one.	Elementary/Secondery (0-12) College (1-4o	(5+)		e during most of wor						
d 212 filed withi Hygiene. ther then end, tre	6th	Dry	Cleaning	Plant Wor		ivate	vate			
be file d othe	17. Father's Neme (First, Middle, Last) Simon Turner				ne <i>(First, Middle, Ma</i> ah Grayson	lle, Maiden Surname)				
should be and Mental a					-					
N 00 00 00	19a. Informent's Neme/Relationship (Type, Print)		and the same of the same	et and Number or Ru			State, Zip Code)			
- 580 7	Josephine Gist - Daughter 20a. Method of Disposition		Dosition (Name of	S.W. Wash			City or Town State			
Or of the Party of		1 Buriel 2 Cremetion 3 Removel from State					other plece)			
Balting Depertment Important any Injury	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019									
Physician	Part i enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death									
/Medical Examiner	transcollete Ceuse (Finel disease or condition resulting to deeth) Due to (or as e consequence of): 10 m fs Due to (or as e consequence of):									
		Due to (or as e consequence of):								
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(58760, rifficate be executed ng physician and sas the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or as a consequence of): 24455 Due to (or as e consequence of):									
ficate be expressed by physician is the buria										
D 0										
o death the atter hed for u	Pert If. Other aignificant conditions contributing to death	underlying cause of	lying cause given in Pert I. 23b. Di-			id tobacco use contribute to the cause of death?				
P hat the hat the od by detac				1 🗆 Yes	2□ No	3 Probably 4	Minknow			
ecords, aw requires as been sign 2 should be ppleted by		24a. Was an autopsy performed? 24b. Were autopsy available prior completion of a			or to					
						.574	of death?			
VITAL H Vician: The Certificate h frector, page				00.00	1 Yes	2) X No	1 ☐ Yes 2	:U N0		
Or Vital Ho Physician: The I rihis certificate he rial director, page		tiont all EDIO	lone 20 000 0	ther	oth (Check only one)		ne (Canada)			
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DIVISION O To the Hoapital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.									
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(0)	30. Name and address of person who completed cause of REVATHY MURTH	death (Item 23a) (Type	e, Print) 130 L	andov	er Ro	1, 0	hever	lg-t		
State	31. Date filed (Month, Dey, Year)	strer's Signeture	1 .							

DHMH 16 Rev 6/95

AUG 2 1 1933 Johnson M. Johnson

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 10:30 AM MARGARET TALBERT 1999 August 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crescent Cities Nursing Home Riverdale Park Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1□ M 2 9 F Months 9 () Yrs. 579-34-8449 5, 1909 Edgefield, SC Mar. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Palmer Park Prince George's 1⊠ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7729 Normandy Road 20785 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaken 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Lewis Gary Gilchrist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10601 Parrish Lane Levonia Stancil/Daughter 20b. Place of Disposition (Wahre of Lile, MD 20721 20c. Location - City or Town, Stele 20a. Method of Disposition cemetery, crematory or other place) 16 Burial 2 Cremetion 3 Removel from State Harmony Memorial Park8/17/99 Landover, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Ave., N.E. Washington, DC 20019 21. Signature of Funeral Service Licensee Co., Inc., Washington, rall 23a. Part1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 4-Colors Due to (or es a consequence of): Due to (or as a cons Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

Physician /Medical Examiner

Box 68760,

P.O.

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physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical signed to P Completed Be Certification: To 27. Manner of Death 1 Ratural ne Hospital or Attanding n 24 hours after death. ne Funeral Director: Att pletely filled in by the fur 2 Accident 3 Suicide 4 ☐ Homicide

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 TYes 2 TNo investigation 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

AUG 1 1 1999

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) M-000Nan

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dele of Death 3. Time of Death Month **Physician** SUSIE THOMPSON AUGUST 6, 1999 12:45am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES If Under 24 Hrs. 8. Date of Birth Hours Min. 7-24-10 If Under 1 Year Months Days 5. Social Security Number 9. Birthpieca (State or Foreign SOUTH CAROLINA 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Days 93 Yrs. Director 241-54-8542 Usuai Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exponent must be not if an annual. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits t Yes 2□ No MD PRINCE GEORGES FORESTVILEE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7429 FLAGHARBOR DRIVE 20747 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 【 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marifal Status Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: BLACK Ş. 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10th DOMESTIC N/A 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be THOMAS ROSEBORO UNKNOWN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) HATTIE M. MISE - DAUGHTER 7429 FLAGHARBOR DR., FORESTVILLE, MD 20747 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pate 1X Burial 2 Cremetion 3 Removal from State 11 - 994 □ Donation 5 □ Other (Specify) BEATTIE FORD MEM. G. MECKLENBURG CO., NC 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the use on each line. Approximete Interval Between Onsel and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Bowe Division of Vital Records, P.O. Box 68760, chemic Physician/Medical 80 ed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably ∮ Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificate hes b or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Depatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To No this funeral 27. Menner of Deet 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Vaturel 1 ☐ Yes 2 ☐ No death. 2 Accident ofter death Director: / 6 Could nof be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homleide 24 hours eft Funeral Di letely filled in Hospital 29a. Certifier 🕪 Sertifying Phyelclan: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and manner as stated. edical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. (Check only one) To the To the To the F 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and fitte of certifier. 30. Name and address of person who completed cause of 31. Dete filed (Month, Day, Year) AUG 0 9 1999

Registrar **DHMH 16 Rev 6/95**

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Patricia Ann Williams 4b. City, Town, or Location of Death 10:54 AM 1999 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner George's Capital Heights Suffolk Street MACE 8. Date of Birth (Month, Day, Feb. 23 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Georgia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F Months Days Hours Min Yrs. 579-76-0191 46 Director Usual Residence of Decedent permit. Peges 1 and 2 should be lited within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercises must be marked appre 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince George's Capitol Heights Directo Maryland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Suffolk Ave. 20743 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritei Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black. Specify: by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Nurses Aide Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlie Moore Patricia Ann McBride 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son Kevin Williams 406 Suffolk Ave., Capitol Heights, MD 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 8/12/99 Glenwood Cemetery Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate intervei Between Onset and Death **Physician** /Medical Immediate Cause (Final Arterioscherotic Cardiovissed as Disease disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other signiffcant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the bed signed by the 3 Probably 4₽ Onknown 1 Yes 2 No p 24b. Were autopsy findings available prior to completion of cause of deeth? should 24a. Wes an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No

The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, i certificate has

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Natural

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3 Suicide

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4 Homicide

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State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number

28a. Date of Injury (Month, Dev Year)

00

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

P11804

1 Yes 2 No

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vester

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28c. Injury at Work?

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death nary pm 4a. Facility Name If not institution, giva street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Regency

5. Social Sacurity Number Vursing Trence torestville exter If Under 1 Yaar Birthpleca (Steta of Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 8. Date of Birth Months Deys Min. 237-48-8265 Hours th. Day 1 M 20 F Yrs. 89 10 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Forest Ville 1 Nes 2 No 10e. Street end Number 10g. Citizen of What Country? 7420 Marlbro Pike 20747 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes A No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1□ Yes 2□ No Specify: 3 Widowed 4 □ Divorcad Black 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Pvt. homes Domestic Pvt. Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John C. Cromartie Lelia Murphy 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Grand Mary J. Williams/Daughter 20b. Pleca of Disposition (Neme of cemetary, cremetory or other plece) 1311 Alberta Dr., Forestville, MD. 20747 Date 20c. Location - City or Town, Stata 1X Buriat 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Pilgrim Rest Bapt Ch.8/13/99 Harrells, NC. 21. Signature of Puneral Service License 22. Name end Address of Fecility CUFFEE Funeral Services plication at caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, and an each line. 20743
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permit. Pagas 1 and 2 should be filed within 72 hours aftar death v Department of Health and Mental Hygiena. important: If item 27 is marked other than "natural; or items 23a any Injury or other traumatic event, the Medical Examiner must page. Baltimore, Maryland 21215-0020 **Physician** /Medical

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Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

1 Yes 250No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 28e. Dete of Injury (Month, Dey Yaer) 28b. Time of

3□ DOA 28c, Injury at

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

27. Manner of Deeth 1 Matural 2 ☐ Accident 3 ☐ Suicida

4 Homicide

5 Pending investigation 6 Could not be datermined

1 Yes 2 No Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurei Route Number, City or Town, Stete)

29a. Certifier (Check only one) Contifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

J- RAO

29c. License number -34525 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) . Registrer's Signature

Road; #220;

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Day 1999 Year August 6, Margret A. Wallenfelt 8:25PM /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Charles County Nursing&Rehabilitation Center LaPlata Charles | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Aug. 4, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (Stete or Foreign Salem, Wisconsin 1 M M 231-36-8742 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2/No Director Maryland Prince George's Temple Hills 10e. Streaf end Number 10f. Zin Code 10g. Citizen of Whef Country? 4505 Poppe Place 20748 USA by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Orlgln? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, Whife, efc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decadent's Education (Specify only highest grede com, 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) 12th College (1-4or 5+) Bookkeeper Private Industry 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Harry S. Helgesen Warneke Emma 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jack A. Wallenfelt, Sr/Husband Same as item 10 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State W Buriel 2 ☐ Cremation 3 ☐ Removal from Sfafe Maryland Veteran's Cemetery 8/12/ Cheltenham, MD. 4 Donation Other (Specify) 21. Signeture de uneral Service Licenses 22. Neme end Address of Fecility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 ales Part . Enter the disease, or complicefic in that caused the deeth. Do not enter the mode of dyling, such as cerdiac or respiretory errest, in ck, or heart fallure. List only one curs on each line. SUPRANUCLEAR PALSY PROGRESSIVE Immediate Cause (Finel diseese or condition resulting in death) Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions confributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 5 ☐ Unknown à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 🗆 Yes 200 No 1 ☐ Yes 2 No Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Date of injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, streef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examinerion end/or investigation, in my opinion, deeth occurred et the time, dele end pieca, end due to the cause(s) and manner stated. (Check only one) 29b. Signefure and tifle of partifier 29c. License number 29d. Dete signed (Month, Dey, Year) M 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) #307 CLINTON MD VENKAT KAMANAN SURRATTS 7501 31. Dete filed (Month, Dey," Year) Registrar's Signature

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Division of Vital Records, P.O. Box 68760,

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WAINWRIGHT, DORIS

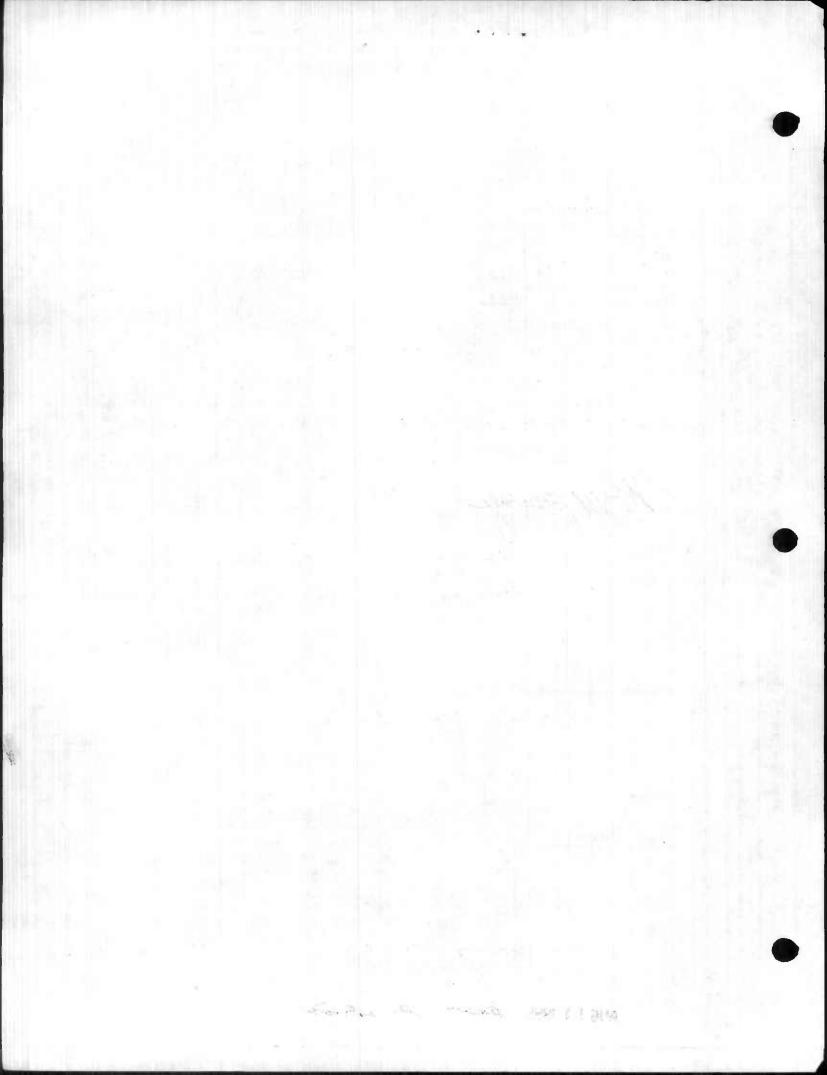
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 12, AUGUST 1999 6:10 P.M. Doris Virginia Wainwright /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death **Examiner** Berlin Nursing and Rehabilitation Center Berlin

| If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 7,1929 Worcester 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Deys Yrs. Maryland Director 70 215-26-6034 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow Worcester Md. ty Yes 2 □ No Director Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò "natural", or itema 23a US 9801 Deer Park Drive 21811 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene important: if them 27 is marked other than "neny injury or other treumatic according Elementery/Secondary (0-12) College (1-4or 5+) Nursing Aide Nursing Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Henry Watson Annabelle Layton 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie Mae Quillen (sister) 9801 Deer Park Dr., Berlin, Md. 21811 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 8-14-99 Lewis Cemetery Willards, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home, 108 William St., Berlin, Md. 21811 used the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, and line. Julas Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit certificate be axacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Box 68760, Physician/Medical Due to (or as a consequence ot): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably C Unknown whe Liver Engline 24b. Were autopsy tindings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? 2X No 1 ☐ Yes 2 No 1 Yes certificate Division of Vital 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending 5 Pending investigation 1 Neturel within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29b. Signeture and title of building 29c. License number 29d. Date signed (Month, Dey, Year) source D02026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Federico G. Arthes, M.D. 46 Teal Circle, Ocean Pines, Md. 21811 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State AUG 1 3 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene



JAMES

Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible.

	State of Maryland / Department of Health and Mental Hygiene	00	0707
Ϊ.	27 PER MED G775 9-20 Cortificate of Death	0 0	6/11/1

Ī	WAITERS A	MEND ITEMS: #23 PART I,	27 PER MEO G775 9	-20 Certificate of	Death	Reg	. No.	6	1411			
	Physician	1. Decedent's Nama (First, Middla, La JAMES EDWA				2. Data of Death	22, 199	(ger	3. Time of Death 05:42 PM			
	/Medical Examiner	4a Facility Name (If not institution, giv	a street and number)		4b. City, Town, or Loc		4c. County of					
	LAdillilei	PRINCE GEORGES I			CHEVERL	4	PRINC	E GE	ORGES			
	Funeral Director		7. Age (In yrs. la	est birthday) If Under 1 Year Months Days	r If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Y 8/2/52	ear)	9. Birthpla Country	ce (State or Foreign			
	P .	Usual Rasidance of Decedant	140-07-	Town and and an								
	vith the Maryla n or 28s-f show be notified at Director	10a. Stata 10b. County		Town or Location Suitland					d. Insida City Limits 1 ☐ Yas 2 ☐ No			
	after death with the Maryland or heme 23a or 28a-f show impact must be notified at / Funeral Director	10e. Street and Number 4604 Da	vis Avenue		0746	10g. Citizen of What Country? U. S. A.						
Baitimore, Maryiand 21215-0020	or he min		12. Was Decedent Evar in U,S Armed Forcas? 1 ☐ Yes 2 ② No If Yas, Giva Year or Datas:	3. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spec ban, Mexican, Puerto R o Specity:	cify Yas or No- lican, atc.)	14. Race - Black, Specify:	Whita, at	ic.			
5-0	"natural", dien En	15. Decedent's Ed (Specify only highest gra	ducation ada completed)	16a. Decedent's Usual Occu	ipation during most of working ed)	g 16	b. Kind of Bust	Inass/Indu	stry			
121	within than the month	Elementary/Secondary (0-12)	College (1-4or 5+)									
12	be filed with tall Hygiene. Id other than event, my Me Comp	11 th 17. Father's Nama (First, Middle, Last,		Unemployed	18. Mothar's Nama	/First Middle Ma	None	1				
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re,	Hoa Hoa ther	20a. Method of Disposition	20h Pia	ace of Disposition (Nema of		Data 20	c. Location - C	ity or Tow	m. State			
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H	Departm Departm Importar any Injur	21. Signature of Funaral Sarvice Licer	sion	Church Cem 22. Name and Addi	rass of Facility,	0 0	0 -					
Ö	Depa Impo any fi	Xany 1	V. Grall	4925 Bi	rass of Facility, Shington Innoughs	Ave. N.	E. Was	nc.). C. 20019			
		23a. Part1. Entar tha disaasa, or com shock, or heert feilura. List only	plications that caused the death.						Approximata Interval Between			
	Physician /Medical Examiner	Immediate Cause (Final disaasa or condition rasulting in death)		L BLEEDING as a consequence of): COMPLICATED BY CI	IRRHOSIS OF L	[VER			Onset and Death			
ox 68760,	death certificate be executed e attending physician and of for use as the burtal-transit siciar/Medical Examiner	Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): d.										
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P.O.	by the tache	ratti. Other alginicani conditions c	algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.						ably 4 Unknown			
	es that igned be det					1 Yea	2 □ No 3					
Records,	been s should					24a. Was an a performe		avai	re autopsy findings ilable prior to apletion of causa eath?			
	The la					1 Yas	2 No	10	Yas 2□ No			
Vitai	entifica sctor, p	25. Was casa rafarred to medical			26. Placa of Death	(Check only ona)		M				
	Physician: this certific ral director.	axaminar? 1∕∑ Yes 2 No	Hospital: 1 ☐ Inpatient 2 💢 E	ER/Outpatient 3□ DOA	ther: 4 Nursing Horr	na 5 🗆 Rasideni	ce 6 Othar	(Specify)				
ion of	Attending Ph or death. ector: Atter thi by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation	(Month, Day Year)	28b. Tima of 28c. Injury W	ury at 2 ork?	8d. Describe how	injury occurred	d				
Division	tal or Attending P rs after death. al Director: Attert led in by the funers Certification;	3 Suicide 6 Could not be detarmined		na, farm, street, factory, office	2	8f. Location (Stre City or Town,	et and Number Steta)	r or Rural	Routa Number,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compi		ysician: To the best of my know niner: On the basis of axaminetic and manner stated.									
	To th To th comp	29b. Signatura and titla of certifier	A	29c. Licer	nse number	290	. Data signed	(Month, D	ay, Year)			
	(1	Mounte Une	Mall	00	ME	A	UGUST 2	23, 1	.999			
		30. Nama and address of person who	completed cause of death (Item:	23a) (Type, Print) 111 Penn Stre	et, Baltim	ore, Mar	yland 2	21201				
	State	31. Data filed (Month, Day, Year)	39 Registrar's Signatu	ura,	:							
	Registrar	AUG 2 5 1999	Beauce	B. porks	/							

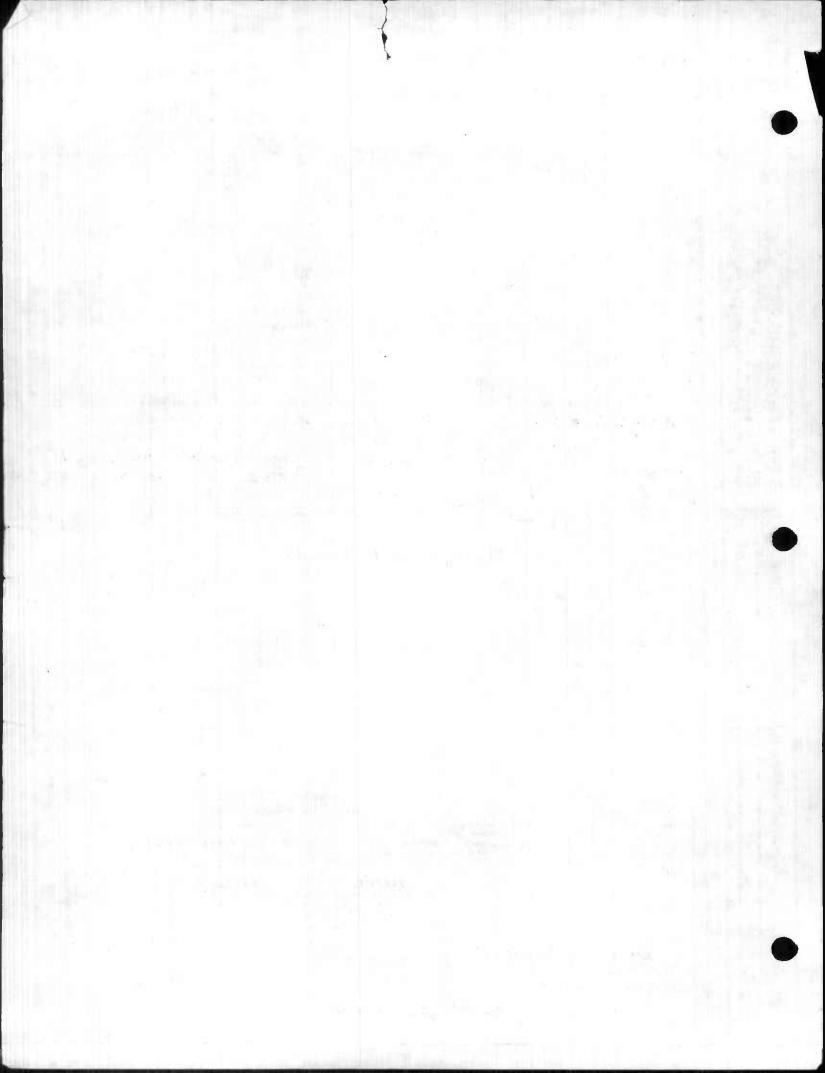
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WILLIAM ACHEAMPONG

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Certifica	ite of Death	Reg. No. 9 9	6	70	13	J

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Physician	1. Decedent's Name (First, Middle, Last) William Kwadjo Achea	mpong	The GAN	2. Date of Death Month AUG	Dey Year 20, 1999	3. Time of Death 2245 PM
/Medical	4a Facility Neme (If not institution, give street and number)		4b. City, Town, or t		4c. County of Death	
Examiner	HOPKINS BAYVIEW MEDICAL CEN	TER E.R.	BALTIMO			
		yrs. last birthday) If Under 1 Y	The second secon		NA 9 Bids	place (Stete or Foreign
Funeral Director	241-08-1878 ¹ ✓ M 2□F 14		ays Hours Min.	8. Dete of Birth (Month, Day, 12-03-		intry)
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anyla anyla						10d. inside City Limits ↓ Ves 2 No
Set of other		Baltimore				43.43
or 2	10e. Street and Number	10f. Zip Co		10	g. Citizen of What Cor	untry?
23a	3678 Kenyon Avenue		213		USA	
) free death with the Mar riters 23s or 28s-f si free mar be nowing	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U,S. 13. Wes Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Rece - Amer Bleck, White	
ind 21215-0020 be filed within 72 hours after death with the Manyland lat hygiens. I other then "natural", or items 23s or 28s-f show went, the Medical Environment be notified. Be Completed by Funeral Director	Monied 2 Merried 1 Yes 2 No If Yes, Give Year or Detes:	1 □ Yes 2 🖎	No Specify:		Specify: B1	ack
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DOF .	9th Grade NA	Student			Student	
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Maryland d 2 should be file th and Mental Hy 7 is marked othe treumatic avent	19a. tnformant's Neme/Reletionship (Type, Print)	19b. Meiling Address (St	reet and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code) 21213
	Dorothy William	3678 Keny	on Avenue	Baltim	ore, Mar	yland
ges tan for Heal or other		b. Plece of Disposition (Name of cemetery, cremetory or other	place)	Dete 2	Oc. Location - City or	Town, State
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Physician	shock, or heart feilure. List only on the on each line.			, , , , , , , , , , , , , , , , , , , ,		tnterval Between Onset end Death
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SIG Seath tor: the	2 Accident investigation 8-20-99			0	reet and Number or Ru	iral Doute Number
DIVISION (I or Attending P after death. Director: After t d in by the funer Certification:	4 A Homicide determined 286. Pleca of Injury - building, etc. (Sc	At home, farm, street, factory, of ecify)	TICE	City or Town	Stote) 36 78 Ke	on Ave
SESS O	70e Codilies 4 C Codition Physics 7 11	home		DRITIMONE	140	,
n 24 hound n 24 hound no Funer pletely file	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medicat Examine: On the basis of exame and manner stated.	ninetion end/or investigation, in	my opinion, deeth occu	red et the time, da	ite and place, end due	to the cause(s)
thin 2 the mple Med	29b. Signeture and title of certifier	290 13	cense number	20	d. Date signed (Monti	n. Dav. Year)
F 1 5 8	A Comment			2.5		
7	Werning Checks wo		O.C.M.E		AUG. 21	, 1999
7	30. Name and address of person who completed cause of death		L P-311		3 01001	
	Dennis J. Chuk, w	111 Penn Stree	et, Balltimo	re, Mary.	land 21201	
State	31. Dete filed (Month, Day, Year) ALIC 2 0 1999	ignature G. Lock	21			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 2135 bright Au. 99 4a Facility Nama (If not institution give street and number 7205 () N.O. 4b. City, Town, or Location of Death 4c. County of Death nio HANDUET Hours Min. 8. Date of Birth (Month, Day 3 -/9 If Undar 1 Yaar Months Days 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 5. Social Security Number 112M 2DF bukwown UNKNOW Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County HANOVER 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA AVENUE OHIO 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yas, Give Race - American Indian, Black, Whita, etc. 11. Marital Status UNKNOW 1 Never Married 2 Married 1□ Yes 2₽No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life._DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Construction CARPENTER UNKHOWN 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) UNKNOWN UNKKOWN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) ODENTON, MD 21113 DIST. A.A. POLICE WESTERN 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burlal 2 Cremation 3 Ramoval from State 4 Donation 5 DOther (Specify) REMOVAL Signature of Funeral Sarvice Licansee 22. Name and Address of Facility DIRECTOR STATE ANATOMY BUARD, BALT, MD Part1. Enter the disease, or omplications that caused the death. Do not antar the mode of dying, such as cardiac of respiratory errest, shock, or heart tailure. List only one cause on each line. Anteriosclerotic Immediata Causa (Final disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

the burial-transit

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signed by

has

certificate

funeral

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

and

law requires that the death certificate be execu P.O. Box 68760

Division of Vital Records.

Examiner

Physician/Medical

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Completed

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Certification:

Medical

any injury or other

Physician

/Medical

Examiner

Director

Funeral

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7 is merked other than "natural", or items 23a or 28a-f show traumetic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Iter

Baltimore, Maryland 21215-0020

with the Maryland

death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 20 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 27. Manper of Deeth 1 Deatural

5 Pending Investigation

6 Could not be determined

Date of tnjury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

31 Date filed

2 Accident 3 Suicide

4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and menner es stated.

2 Vedical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

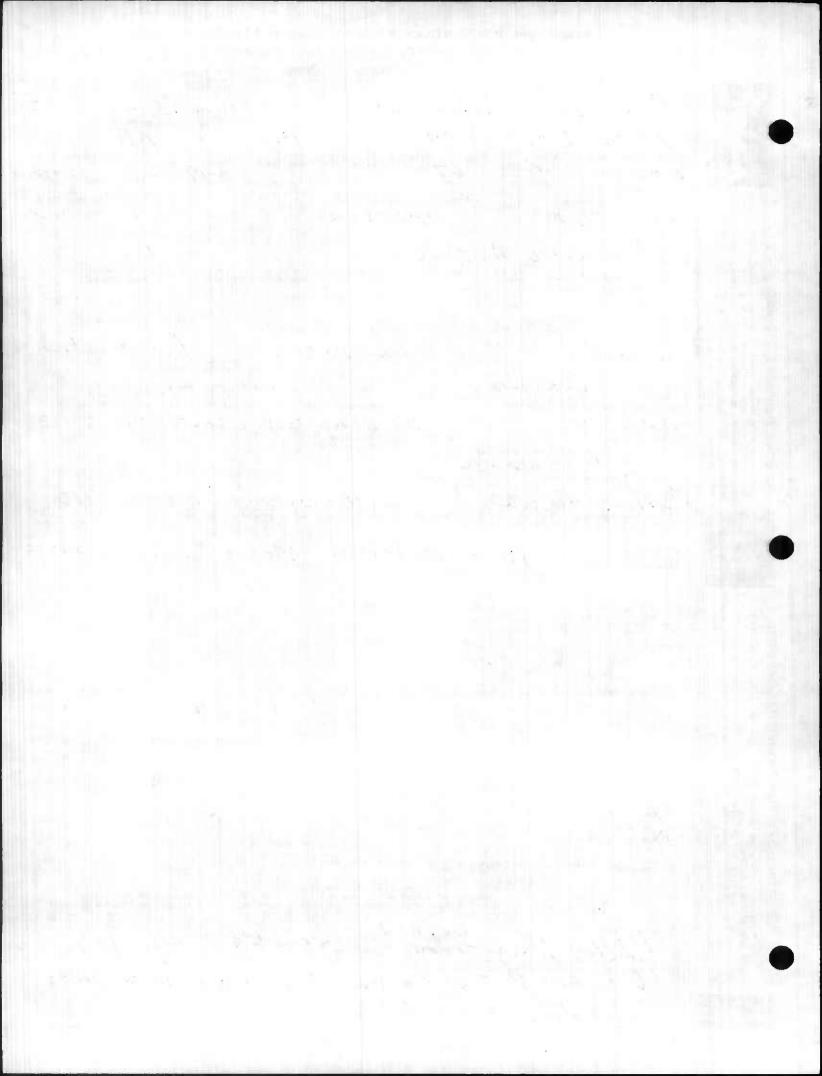
29b. Signature and title of certifian

Deguty

29c. License number D06054 29d. Data signed (Month, Day, Year)

cause of death (Item 23e) (Type, Print) JONES, mo 693 AMERICA 21036

State Registrar 32. Registrer's Signeture ener



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month HELEN **Physician** BROOKS CATHERINE AUGUST 4:50 PM /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RICHIE HOSPICE

7. Age (In yrs. last birthday) If Under 1 Yaer

Months Days BALTI HORE
If Under 24 Hrs. 8. Data of Birth
(Month, Day, Year) JOSEPH 5. Social Security Number Birthplace (Stata or Foreign Country) 1 M 2 XF 215-24-5260 MARCH 07, 1919 MAR **Usual Residence of Decedent** 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CITY Vo Yes 2□No Director MARVLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) STREET USA. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Giva Year or Datas: 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1月 Never Married 2 Married 1 Yas 2 No Specify: à BLAC 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ntary/Secondary (0-12) College (1-4or 5+) PRIVATE FAMILIES GRADE DOMESTIC WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 8 UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 25/ST. MATTHEWS ST. BALTIMORE, MD. 21205
ace of Disposition (Nama of Data 20c. Location - City or Town, State (NEICE) MARY TOMARCHIO 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State -27-99 BACTIHORE, HARYLAND 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 21. Signature of Funeral Survey License 22. Name and Address of Fecility JR. FUNERAL HOME JOSEPH H. BROWN 2140N. FULTON AVE. 23a. Part. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory splock, or heart failure. List only one cause on each line. MD. 21217 5 month Immediata Cause (Final disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot) Physician/Medical Dua to (or as a consequance of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yas 2 No 1 Yas 2 No. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) examiner? Hospital: Other: 4 Nursing Home 5 Residence (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.

Discontinuous of the basis of examination end/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the 29a. Certifier iner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at tha time, date end place, and due to tha cause(s) and manner stated. (Check only one)

of Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Division

8/25/99

Brooks

Funeral

Director

them 27 is marked other than "natural", or flams 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiens. Important: if them 27 is marked other than "nature any injury or other treumstic event and onde.

Physician

/Medical

Examiner

ettending physician and for use as the buriel-transit

this certificate

Baitimore, Maryland 21215-0020

State Registrar DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) AUG 3 0 1999

29b. Signatur

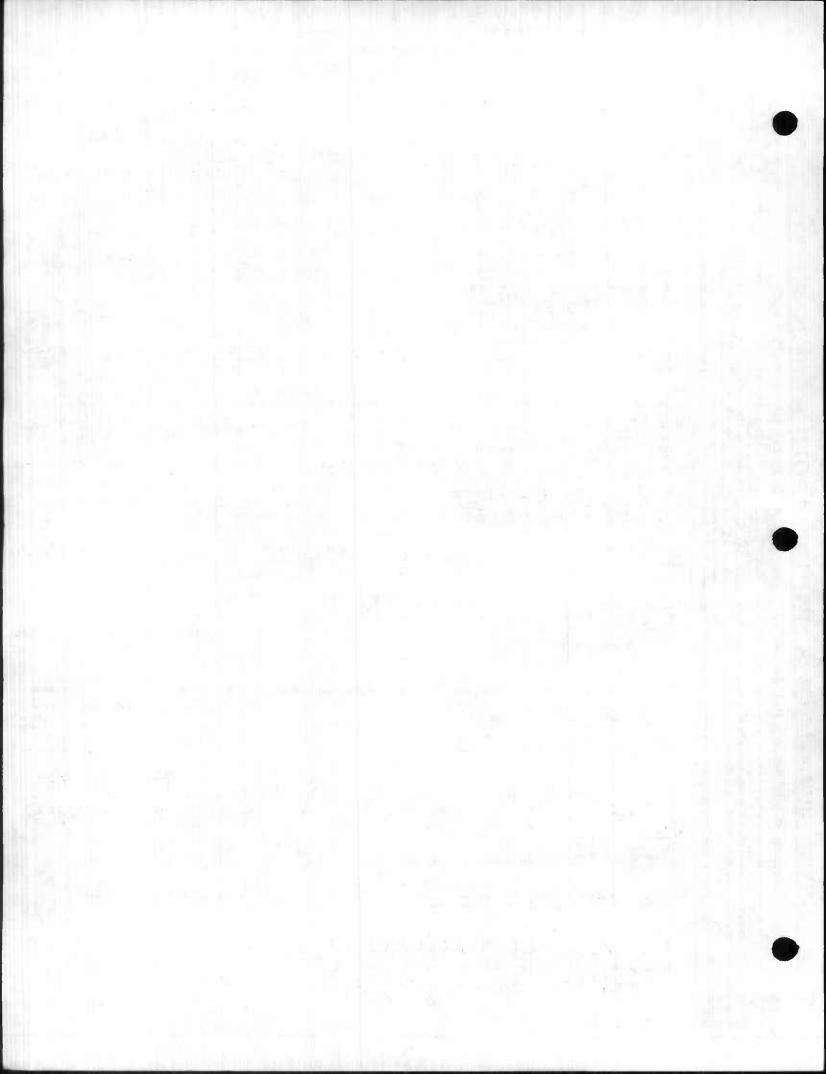
32. Registrar's Signature

on who comp

(Type, Print)

29c. Licensa number

29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 9:30AM /Medical 4b. City, Town, or Location Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Sunrise Assisted Living Columbia Howard 8. Dete of Birth (Month, Day, Year) 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2KX Months Hours 254-26-1770 77 Yrs. Feb. 6, Director 1922 Georgia Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2□ No Director Maryland Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Phillip Powers 20707 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZYDNo If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Menitel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ **3**CWidowed 4 □ Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be William E. Mackey Anna Laura White 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn A. McCormick/Daughter 5005 Orchard Drive Ellicott City, MD 21043 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 8/30/99 Elkridge, Maryland 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Enter the Approximete Intervel Between Onset end Death Immediate Ceuse (Fine) disease or condition resulting in death) Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 ☐ Yaa 2 ☐ No by 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? 1 Yes 1 Yes 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 2 No Other: 4 Mursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Menner of Death 28b. Time of 28c. Injury at Work? 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide to Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

**Discrete: The deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier

The law requires that the death certificate be axecuted Box 68760.

the Maryland

"natural", or flams 23a or 28a-f ahow oficial Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.
In: If item 27 Is marked other than "natural", or home 23 any or other traumatic event, the Mental Exerciting mass

important: If it any injury or Department

Physician /Medical

Examine

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Baltimore, Maryland 21215-0020

signed by the a Division of Vital Records. P.O. certificate or Attending Physician: this After 24 hours after death.

Funeral Director: A filled in by Hospital completely within 2 \$

> State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year) AUG 3 0 1999

(Check only one)

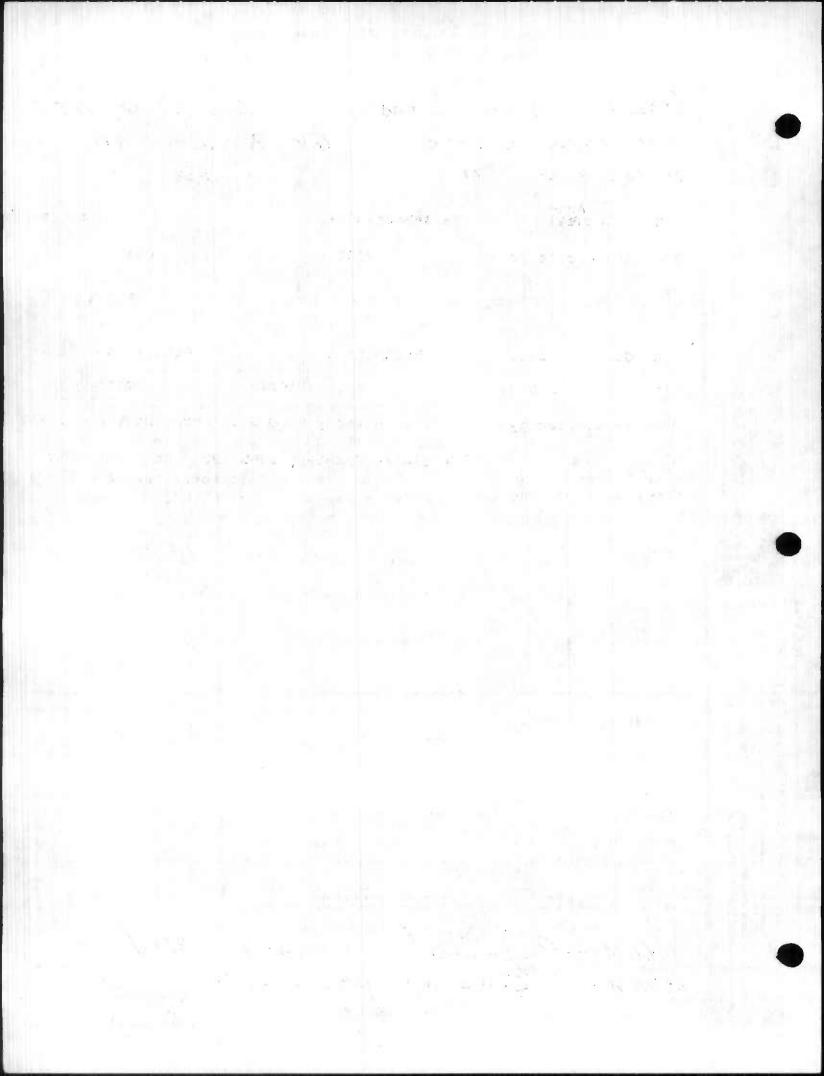
29b. Signature and title

29d Date signed (Mongh, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q

			Certificate of Death		eg. No.	9 2108	<i>(-</i>
	Physic /Med		RONALD Jerry Bradby	2. Data of Daal Month AUG	Day 24	Year 99 115	ath
7	Exami	ner	4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Local Circle GRN B	ation of Daath	4c. County	AA.	
	Funeral Director		5. Sociel Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day) 07-17-	Year)	9. Birthplaca (State or Fo	oreign
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	ours efter death with the Manylan el', or fems 23e or 28e-1 show Examiner must be notthed at	by Funeral Director	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spec If Yes, specify Cuben, Maxican, Puarto Ri 14. Was Decedant of Hispanic Origin? (Spec If Yes, specify Cuben, Maxican, Puarto Ri 15. Was Decedant of Hispanic Origin? (Spec If Yes, specify Cuben, Maxican, Puarto Ri 16. Yas 1	cify Yas or No- lican, atc.)	Bleck	- American Indian, k, Whita, atc. Black	
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Man	d 2 short h end h ls ma		19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Streat end Number or Rurel				212
Baltimore,	Peges 1 and 2 nent of Health int: If Item 27 I		Francis K. Bradby 20a. Mathod of Disposition X Burial 2 Cremetion 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 1019 Reverdy Road B 20b. Placa of Disposition (Nama of cemetery, cramatory or othar place) Baltimore Cemetery 09-		20c. Location - (City or Town, Stata	
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60,	Physician /Medical Examiner bus updates the principle of the princip	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or shock, or heart failure. List only no cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury) Cause (Disease or injury)			Minute Vears	th
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tal		e Con	25. Was case refarred to medical 28. Place of Death (1 □ Ya		1 ☐ Yas 2 ☐ No	
<u> </u>	00	To B	28. Place of Death (axaminar? 1			r (Specify)	
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	To Too	2	29c. Licensa number Deputy 29c. Licensa number DOL 05 4 30. Nama and address of person who completed causa of daeth (item 23a) (Type, Print) United Month, Dev. Year) 31. Data filed (Month, Dev. Year) ALIG 3 0 1999	29	8/24	(Month, Day, Year)	
	γ		30. Nama and address of person who completed causa of daeth (item 23a) (Type, Print) William P. Jones, MD 695 Ame	erica	21	035	
	Sta	te	31. Data filed (Month, Dev. Year) ALIG 3 0 1999 32 Registrar's Signatura 4 Apart 1				



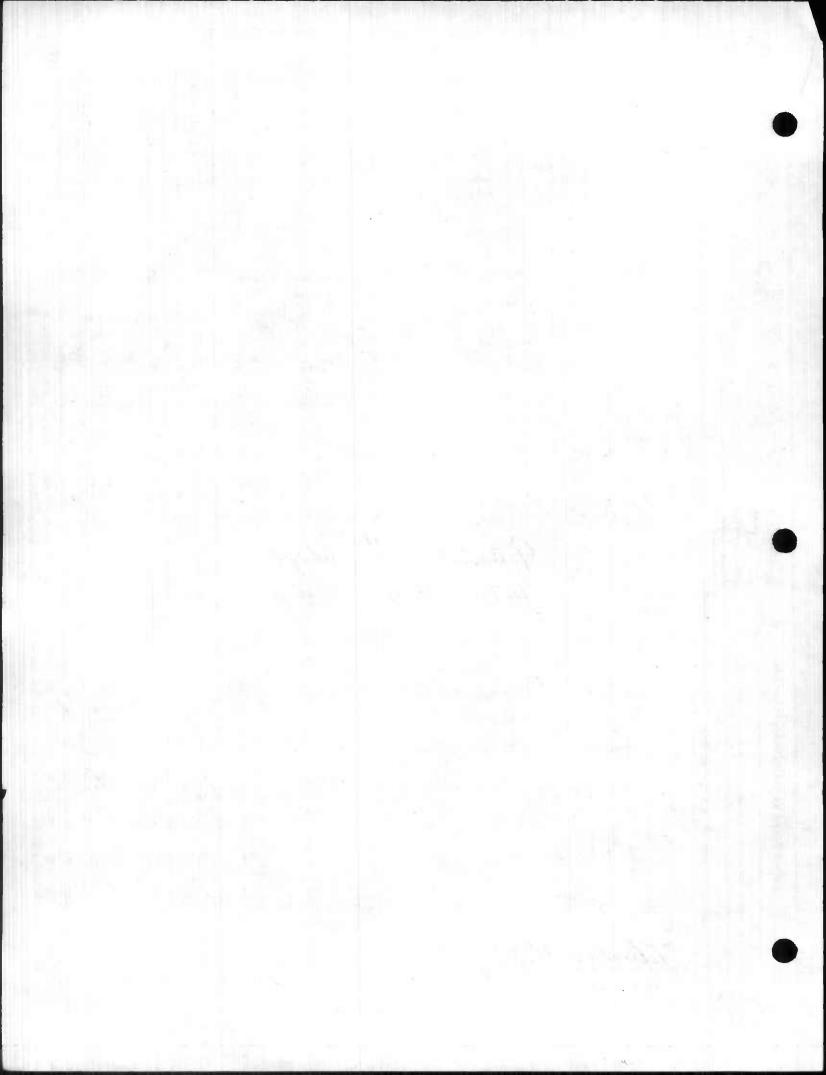
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	Physici		Steve	D.	Bla	nd					Month AUGUST	Dey 26,	1999	13	04 PM
	/Medio Examin		4e Facility Name (If not Institution UNION MEMORIA	, give street and nu	mber)				4b. City, To BALT		cation of Deeth		ounty of Death		
	Funeral Director		5. Social Security Number 212-50-1882	6. Sex ↓ M 2 F	7. Age (In yrs. 54	ge (In yrs. last birthday) If Under 1 Yeer If Under 24 Hr. Months Days Hours Mir				24 Hrs. Min.	8. Dete of Birth (Month, Day	9. Birth Cou	intry)	ate or Foreign	
	-		Usual Residence of Decedent								07-10	1-45	M	D	
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	Mar And	tor	MD N	A	В	altim	ore							17	Yes 2□No
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020	hours after bursi', or its al Examine	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Yeer or D	VO		1 🗆 Yes	34-14No	Specify:			Sp	pecify: Bl	ack	
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	8		30. Name and address of person v	who completed caus	e Asseth (Iter	7 n 23a) (Type, 11 Penr	Print)	eet.	Balt	imor	e, Mary	land	21201		
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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Daje of Death 3. Time of Deeth Bluford Month 06 **Physician** 99 03:0 Pm evI /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deafh Examiner 3709 AVENUE BACTIMOVE BELLE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** 12 M 2□ F Hours Unknown cinknown Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at BACTIMORE 1 ☐ Yes 2 ☐ No MI Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 3709 Avanue BEILE death y permit. Peges 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural". ***—any injury or other traumatic even*** 14. Race - American Indian, Black, Whife, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marifal Stetus CLAR NOWN 1 | Yes 2 | No
If Yes, Give
Year or Detes: [M. K. NOWN] 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLAC þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Industry Etementery/Secondery (0-12) College (1-4or 5+) UNKNOWN UNKROWY UNKNOWY 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) UNKNOWN UNKNOWY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) BACT, MID
Dete 20c. Location - City or Town, State BACT. CITY POUCE MORTHWEST DIST. 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20e. Method of Disposition 1 ☐ Burlet 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) / TENEUUH 21, Signalure of Furtheral Service Licensee 22. Name end Address of Fecility In AToney Bonne, Bigg. MI mall use, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest, List only one cause on each line. Approximete Intervel Between **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Coronary arterial disease Examiner Due to (or es e consequence of): Examiner Hypertension physician and s the bunal-transit the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Seiznre disorder Physician/Medical Due to (or es e consequence of): 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2N No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were europsy findings evalleble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed certificate has I or Attending Physician: ofter death. Director: After this certific funeral director, 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ Yes 2 No 70 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of tnjury (Month, Dey Yeer) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred 27. Manner of Deeth Certification: 1 Naturel 2 Accident 5 Pending 1 Yes 2 No Investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, sfreef, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital (within 24 hours el To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et fhe time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at fhe time, date end piece, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 030115 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) T. Ohiokpehai, mo 2600 Liberty HGTS Ave B91+, mo 21215

State Registrar 31. Dete filed (Month, Dey, Year)

AUG 3 0 1999

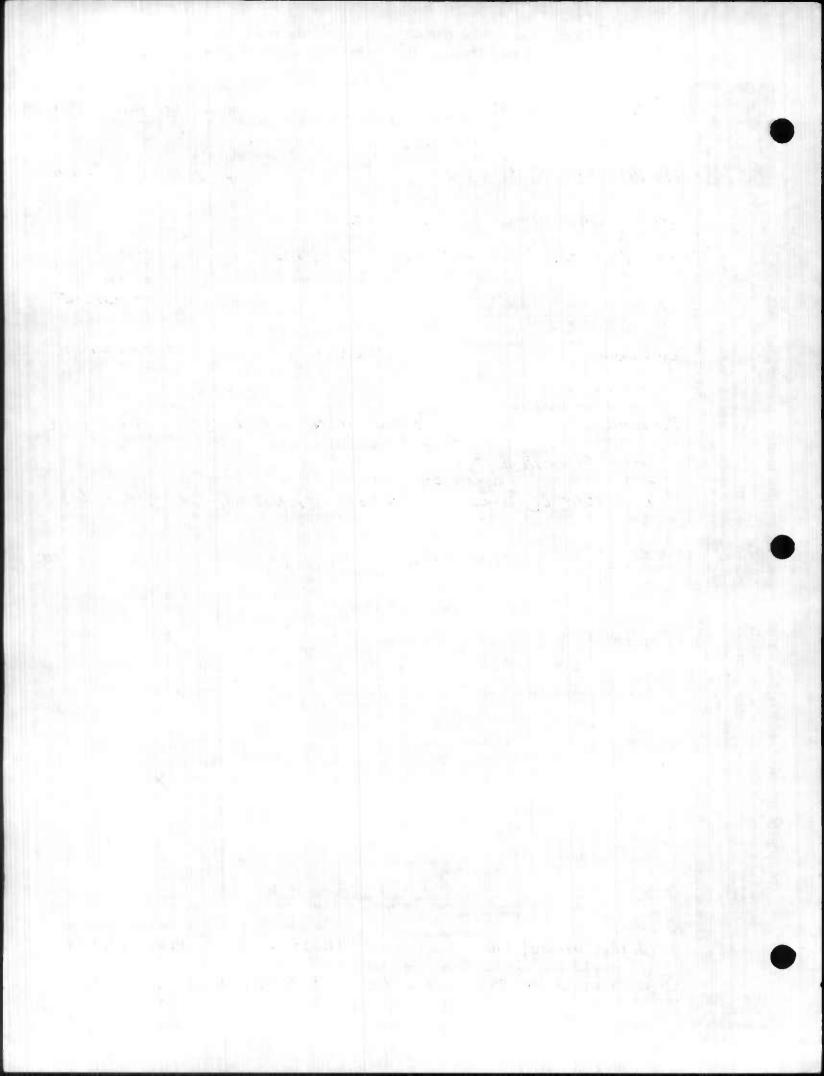
32. Registrer's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 7 0 8 5 Certificate of Death Reg. No.

			C	ertifica	te of	Death	B	eg. No.			
	1. Decedent's Name (First, Middle, I	.ast)					2. Dete of Deet Month		Year	3. Time of Dea	
Physician /Modical	Virginia Bo	osworth					August		999	05:10	
/Medical Examiner	4a Facility Name (If not institution, g	ive street and number)		-		4b. City, Town, or	Location of Deeth	4c. County	of Death		
	Johns Hopkins Bo	uview Medical	Center		-	Baltimo	re				
Funeral	5. Social Security Number 6.	Sex 7. Age (In)	rs. last birthd	Months	er 1 Yea Day			Year)	9. Birthp	lace (State or Fo	
Director	Usuat Residence of Decedent						0 7	10	01.	2,0000	
8 m	10a. State 10b. County	10c.	City, Town or	Location					1	0d. Inside City Li	
titled titled ctor	MB BACTI	more	Dur	dalk						1 Yes 2	
ter coests with the maryand fears 23e or 23e-f show frer must be notified at furneral Director	10e. Street end Number	lince AD	T. 300		ip Code	222	10g. Citizen of What Country?				
0 0 0	11. Maritel Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 □ Yes 2 1 No if Yes, Give Year or Detes;	n U,S. 1	3. Was Dec If Yes, sp		Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Bla	ca - Americ ck, White,		
natural.	15. Decedent's (Specify only highest g	Education	16a. De	cedent's Us	ual Occi	upation e during most of wo	rkina	16b. Kind of B	usiness/inc	dustry	
ygiene. Mr than *naturn II, the Medical Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	iii	e. DO NOT	use retir	ed)	9	UN	KNO	004	
	17. Fether's Name (First, Middle, La.	et)		UPR	100	-	me (First, Middle, I	Aalden Sumar	ne)		
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and Men a marke numeric		•	1						0		
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Departmen Important any Injury ance	21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or co. 25a. Part1. Enter the disease, or co. 25a. Part1. Enter the disease.	ensee DIREC	707			ress of Fecility	nnu B	0 03	AIT	ILID	
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this certificata ral director, pag	25. Was case referred to medical exeminer?	Hospital:				ther:	ath (Check only or				
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ath. r: After ne funa ation	Neturel 5 Pending investigat	28e. Dete of injury (Month, Dey Year	r) Inju		28c. In W	ork? □ Yes 2 □ No	20d. Describe III	ow injury occu	160		
at Director: After the line by the funara Certification:	3 Suicide 8 Could not 4 Homicide determine		At home, farm, ecify)	, street, facto	ory, offic	Э	28f. Location (Si City or Town		ber or Rura	al Route Number,	
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: 7		Physician: To the best of my aminer: On the basis of examend manner stated.									
M Me	29b. Signeture end title of certifier			2	9c. Lice	nse number	2	9d. Date signe	ed (Month.	Day, Year)	
> - 0	DG. ran Egm	and MD			PI	1039		Augus	17,	1999	
	30. Name and address of paralon wh	o completed cause of deeth (Item 23e) (Ty		ue,	Baltimov	e, MD al	224			
State	31. Dete filed (Month Day, Year)	32. Registrar's Si		-,							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert M. Cohen 1999 August 21. 6:00 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1619 Drexel Street Takoma Park Prince George H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 31, 1 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 10/M 2□ F Months 102-05-3465 82 New York Director Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ehow mast be notified at 1 ☐ Yas 2 No Director Prince George Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1619 Drexel Street Items 23a 20912 death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2000 If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes XXNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ified within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Radio Dispatcher Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Isadore Cohen Gertrude Sarensky 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Cohen/Wife 1619 Drexel Street, Takoma Park, Maryland 20912 of Disposition (Name of Dete 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial XXCremation 3 ☐ Removal from State Baltimore Washington Cr. 8/27/99 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 (Signaphrepot Funeral Segrice Libera 22. Name and Address of Facility Fleck Funeral Home. Inc. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate

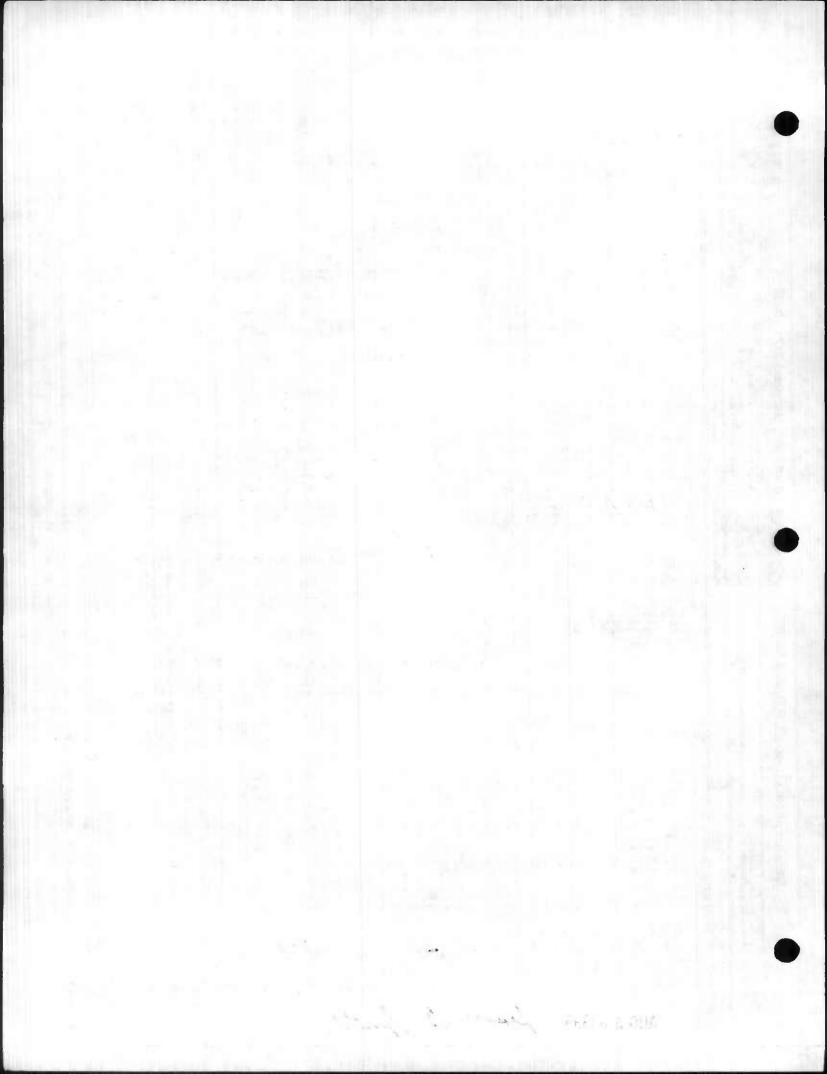
List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Causa (Finet Kulmoney disease disease or condition resulting in death) Examiner Examiner roedisn physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) 158 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4□ Nursing Home 50 Residence 6 □Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? Division After 1 2 Natural 5 Pending efter death. Director: Af 1 Tyes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 6 filled in 24 hours a Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical completely (Check only one) To the P 29c. License number 29d. Date signed (Month). Day, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) RD, STE7, BLADENSBURG MO 2010 31. Date filed (Month, Day, Year)

State Registrar

AUG 3 0 1999

32. Registrar's Signature

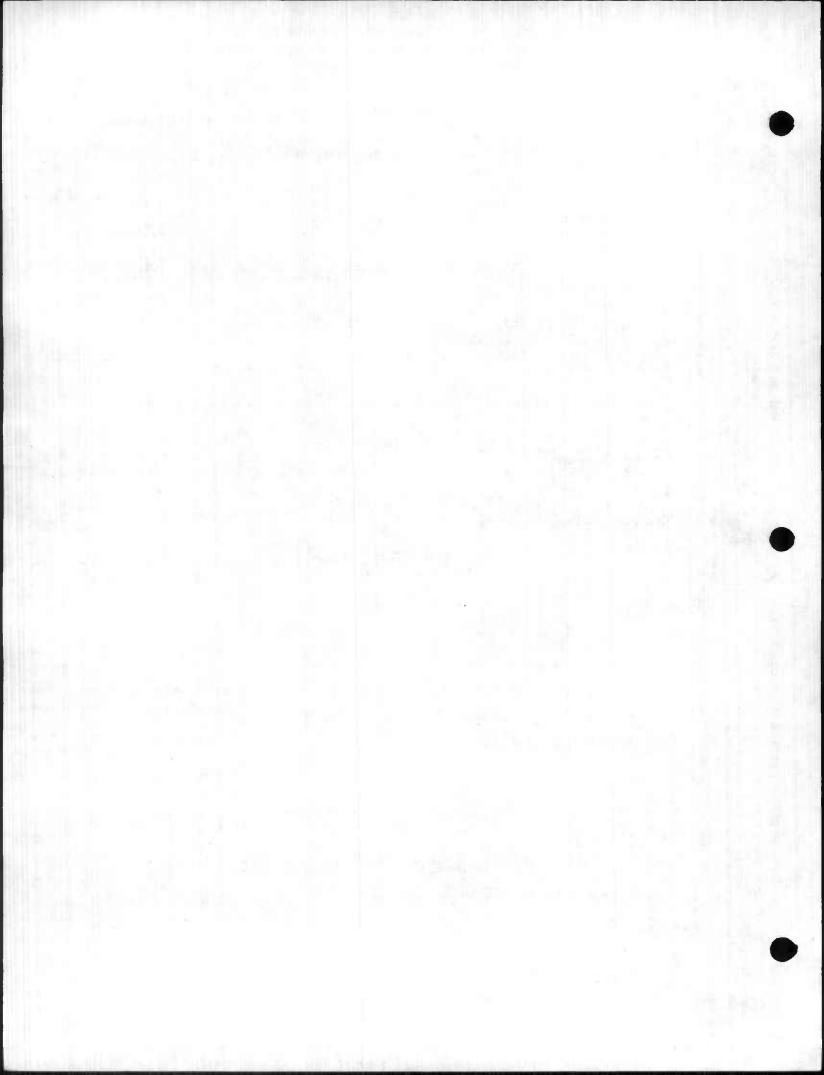


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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 26 Day Aacon Cummings 0635 /Medical 4a Facility Name (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1₽M 2□ F 214-54-5435 47 Yrs. Director 02-15-52 MD Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23a or 28a-f show the Medical Examinat must be notified at 1 Yes 2 No Director MD NA Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 3705 Monterey Road Baltimore USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. filed within 72 hours after of Hygiene. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) pemit. Peges 1 end 2 should be filed with Department of Health and Mental hygient important: if flem 27 is marked other the eny injury or other trauments. 10th Grade Self-employed Disabled 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Cornelius Cummings Helen V. Moody 19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 21230 19e. Informent's Neme/Ralationship (Type, Print) 3705 Monterey Road Baltimore, Maryland Cynthia Cummings 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Special) Greenmount Cemetery 08-28-99 Baltimore, MD 21. Signature of Funeral Service Losses 22. Name end Address of Fecility Baltimore, Maryland @1202 WM.C.March FH 1101 E. North Avenue Thus the disease or templications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. Unit only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Vibrio vulnificus sepsis 4 days diseese or condition resulting in death) Examiner Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last pug Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE, HEPATITIS C CIRRHUSIS, FULMINANT Division of Vital Records. à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? DISSEMINATED INTRAVASCULAR COAGULATION MCYATIC FAILURE 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifice 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 2 Neturel 5 Pending 1 Yas 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifian 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sound E. Karlen, - Mo ... august 26, 1999 RES 000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 21287 DAVID F. KARLAN, MO; GOO N. WOLFE ST; TOWER 110; 32. Redistrer's Signeture 31. Date filed (Month, Dey, Year) State AUG 3 0 1999 sacks/ Registrar



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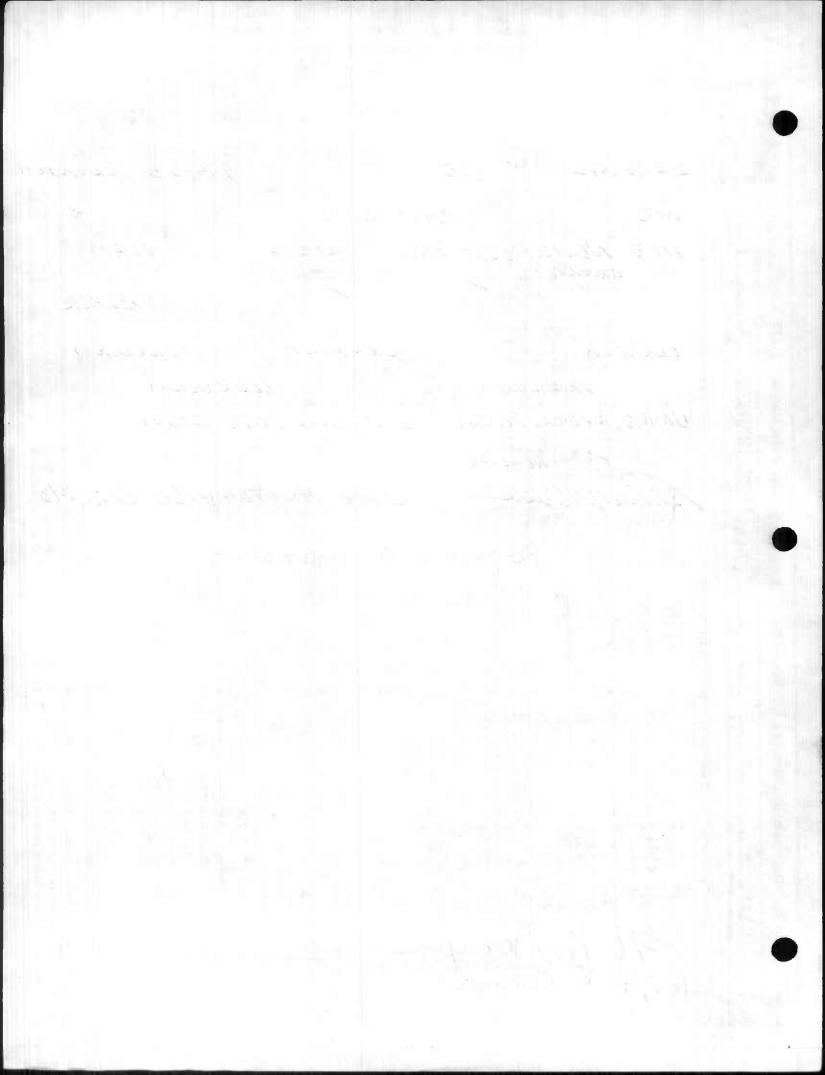
State of Maryland / Department of Health and Mental Hygiene 99 27088

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State Registrar

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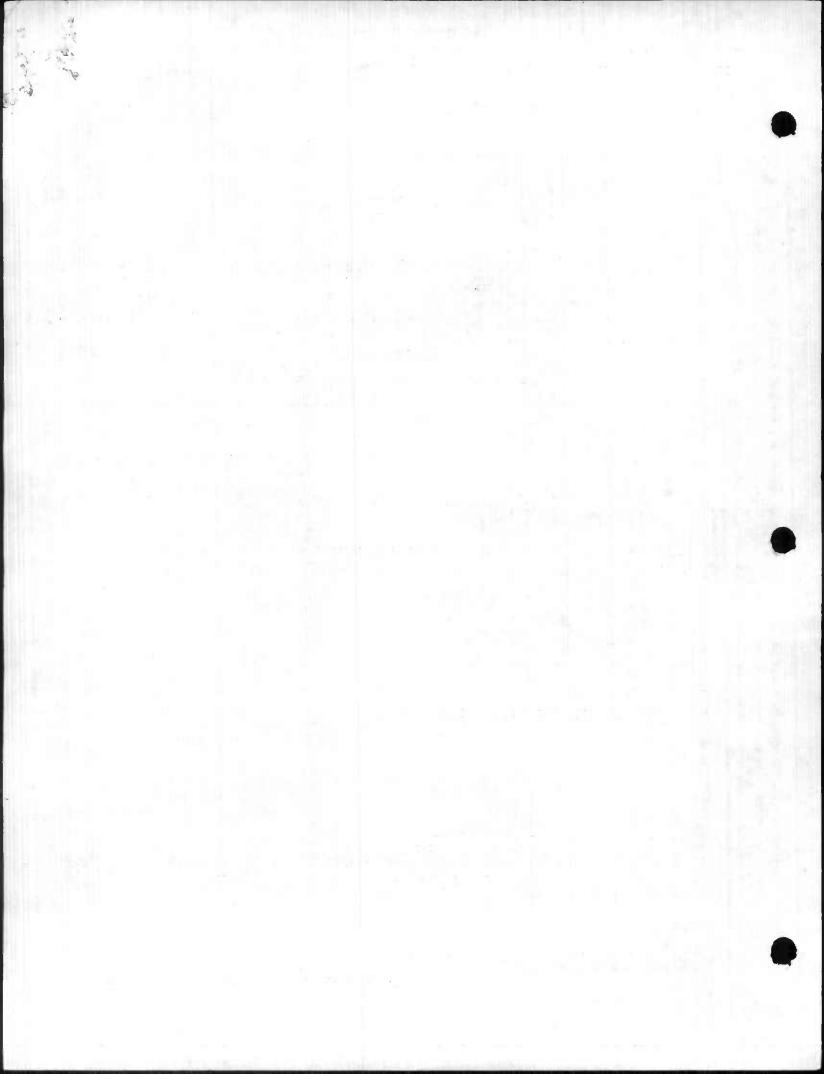
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Stephen 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Radentz 32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** August ES ACKE HUpm /Medical Gity, Town, or Lower BALT MORE YOUNGER SHOWN AND THE SHOWN 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner 7. Age (In yrs. lest bilthdey) ttosp STELLA MARIS AT If Under 1 Yeer 6. Sex 5. Sociel Security Number Birthplece (State or Foreign Country) 1 M 2 1 € Months Deys Yrs 212-74-4406 Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No BAltimore MD Director N 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 21229 USA 4302 Herrie 23a SEMINO E Funeral amil. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiena. 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 NO It Yas, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Blac g 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elamantary/Secondary (0-12) SSISTAN HOSP, to 12+h IA 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Be To DOPER Kobert lak vanita 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) #20 4302 SemiNole Balto Hd 21229 0/65-DON HERNAN 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition injury or -27-90 4 ☐ Donetion 5 ☐ Othar (Specify) tea (Rematora 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses West Ra MRCh FUNCE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition rasulting In death) Lance Examiner Dua to (or as a consaguance ot) Examiner physician and s the burial-trans Sequentially list conditions, if eny, leading to Immediate ceuse. Entar Underlying Cause (Diseese or Injury that Initiated events resulting In daeth) Last Due to (or es e consequence of): certificate be axecu Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or es e consequence ot): 200 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Ne 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed been completion of ceuse of death? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Placa of Daeth (Check only one) Hospitel Other: 4 Nursing Home 1 Yas 2 No 5 □ Residence 8 □ Other (Specify) ho > p 1 U 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how Injury occurred 27. Marrier of Deeth 28h Time of : After t Certification: 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? or Attending Naturel 5 Pending Investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, atc. (Specify) 4 Homicida 24 hours a Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and due to the cause(s) and mannar as stated.

Madical Examiner: On the basis of exemination end/or investigation, in my opinion, daath occurred at tha time, date and place, and dua to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the I within 2 29d. Dete signed (Month, Dev. Year) 29b. Signeture end title of certifia 29c. License number

Registrar DHMH 16 Rev 6/95

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32. Registrer's Signature

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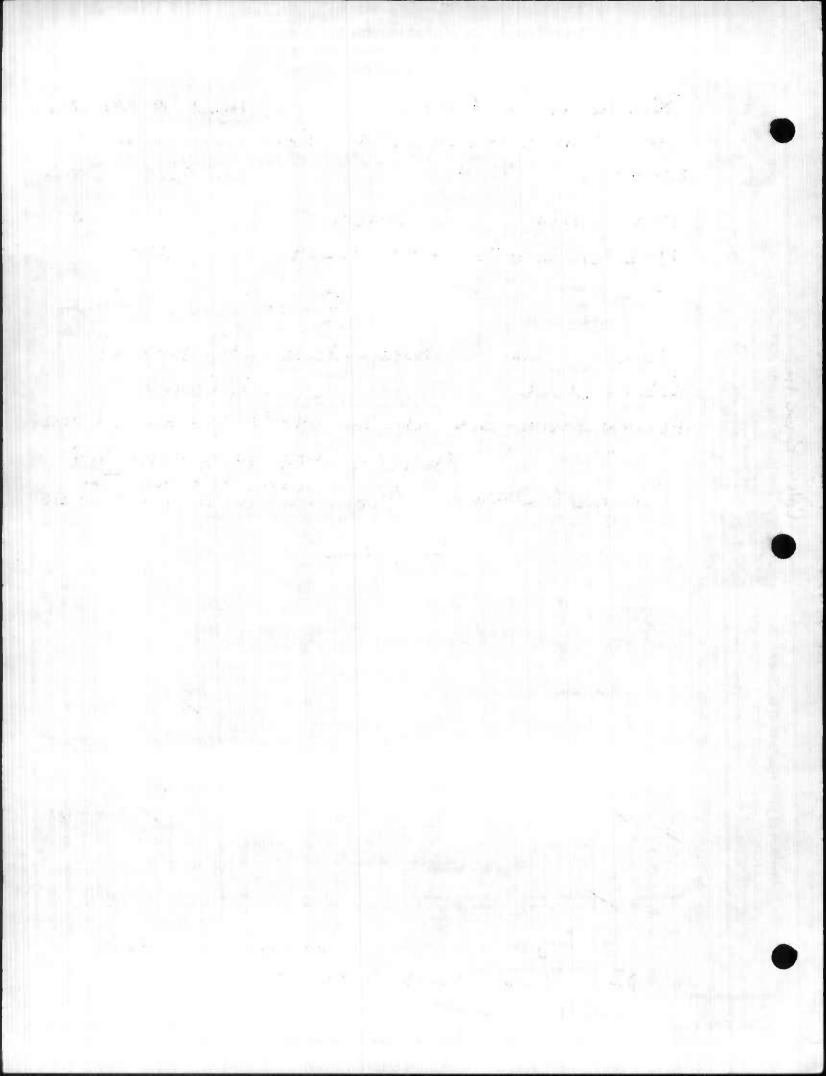
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30. Name endeddress of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** eShAZO August 4b. City, Town, or Location of Death 2:10 A.M Son Ander /Medical 4c. County of Death 4e Facility Name (If not Institution, give street end number) **Examiner** tranklin Square 5. Social Security Number Baltimore 7. Age (In yrs. last birthday) Il Under 1 Year Rosedal 14 If Under 24 Hrs. Hours Min. 8. Date of Birth (Month/ Day) Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 229-16-7705 Director Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits from 27 is marked other than "natural", or from 23a or 28a-f abov other traumatic event, the Medical Extensions must be notified as 1 Yes 2 No timore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5. 2123 16 Funeral Lomon Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. 11. Maritel Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 te marked other than "natural", or item 1 Never Married 2 Married 1□ Yes 2⊠ No Specify þ 3 ☐ Widowed 4 ☐ Divorced SIAC Year or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WORKER A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be JeshAZD 00 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 dailet 16 Lomona 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Hores! Cem. 22. Name end Address of Facility 21 Simethur of Funeral Service Licenses etts CAroline 5+ 2/2/3 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, and failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final 3/ears disease or condition resulting in deeth) Ter Examiner Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Physician/Medicai Due to (or es e consequence of): USe as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy Chronic Obstructive Pulmonary Disease Hypercholesterolemia 25. Was case referred to medical examiner? 1 Tyes certificate Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 24 hours after death. 2 Accident Investigation 6 ☐ Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

State Registrar

9000 enna eena 31. Date filed (Month, Day, Year) AUG 3 0 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

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29c. License number

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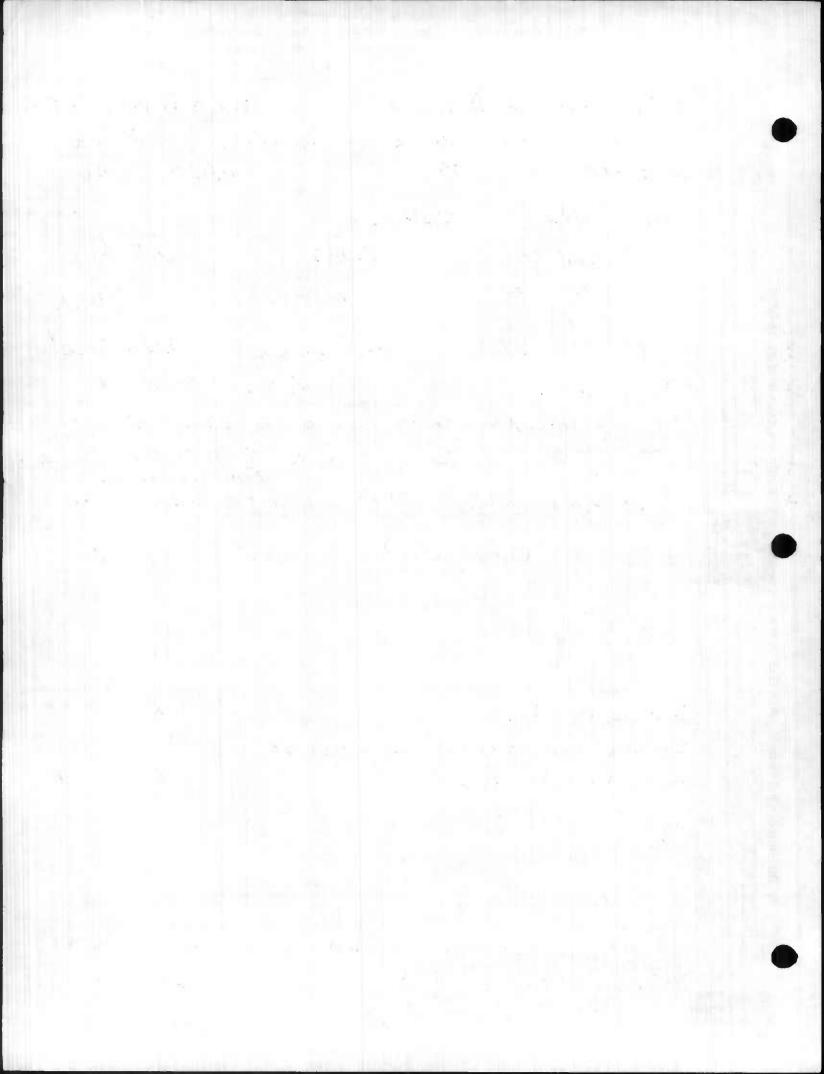
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Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle | ast) 2. Date of Death 3. Time of Death **Physician** Month 8 26 1999 3:20 p.m. Charles E. Ford /Medicai 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death Stella-Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign Country) Maryland 8. Date of Birth (Month_Day, **Funeral** 15 M 2 □ F Months Days Hours 80 Director Yrs Aug 214-12-1621 Usual Residenca of Decedent filed within 72 hours after death with the Maryland 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Director 1 ☐ Yes 2 ☐ No MD Baltimore Sparks 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 14 Rainflower Path 21152 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ģ 3 □ Widowed 4 □ Divorcad Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Agent Insurance Company rages 1 and 2 should be file.
Then to Health and Mental Hyo wit: If Item 27 is marker.
Ty or other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Stephen Hyland Ford Louise Escher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) Rosemarie E. Ford/Wife 14 Rainflower Path Sparks, MD 21152 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or Green Mount Crematory 8-28-99 Baltimore, MD 21. Signature of F 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. humann 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Ent., the discussed the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Dementia Examiner Due to (or as e consequence of): Physiclan/Medical Examiner cartificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Lest Due to (or as a consequence of): Due to (or as a consequence of) USB as The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 should Completed 24a. Was an autopsy performed? certificate has been 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 Yes 2 No this filled in by the funeral Certification: 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide after ò To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43725 8/27/99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Rd., Timonium, MD

32. Registrer's Signature

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31. Date filed (Month, Dey, Year)

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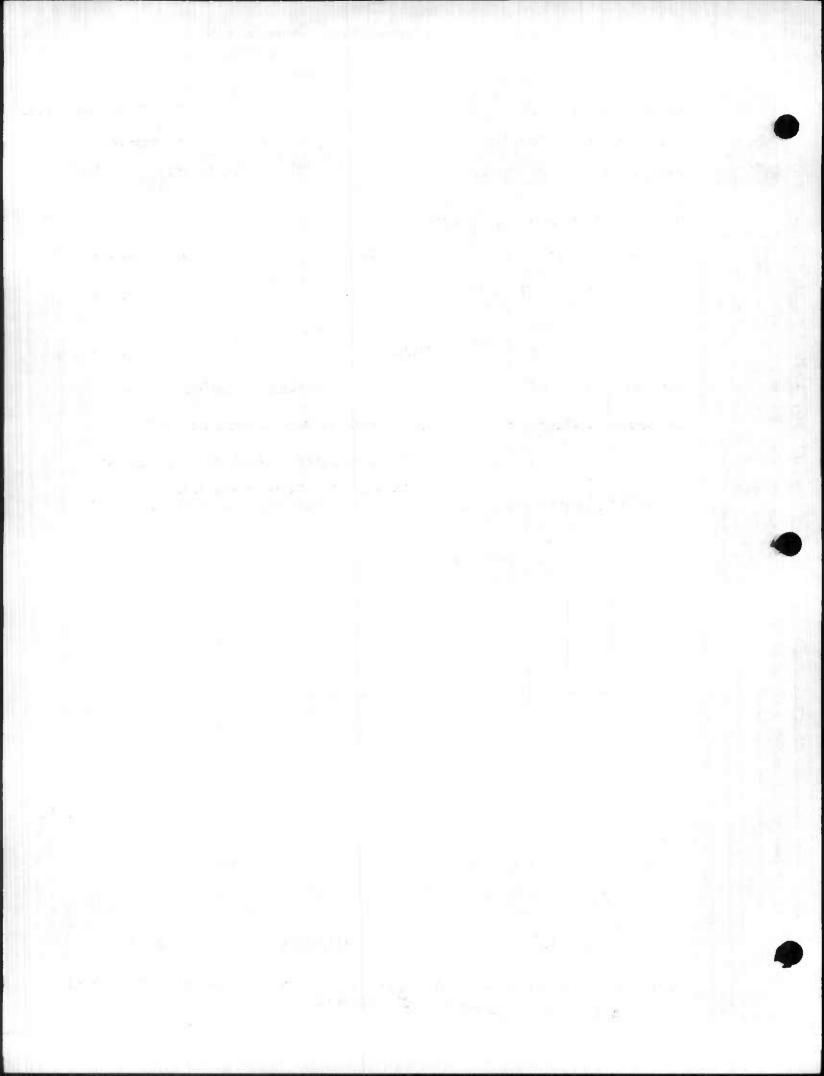
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Fiedler Anthony 25 August 1999 9:04 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore **Baltimore** If Under 1 Year if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days XXM 2 F 212 03 1652 86 Yrs Jan. 6, 1913 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland **Baltimore** Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8015 York Rd. 21204 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Stetus 14. Race - American Indian, Black White etc. 1 Never Married 2 Married XYes 2 No White 1 Yes X No Specify. Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Defense / Comerce 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Fiedler Nicholas Hildebrand Marie 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8015 York Rd. Apt. B4, Baltimore, MD Dorothy B. Fiedler / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 8/27/99 Baltimore, MD CAFA Stephen D. Lohrmann P.A. Olimann 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediete Ceuse (Finai Laryngeal Cancer
Due to (or es e gossequence of): ears disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of) Part il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? STYRE 2 No. 3 Probably 4 Unknown P Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Be 25. Was cese referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 9 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

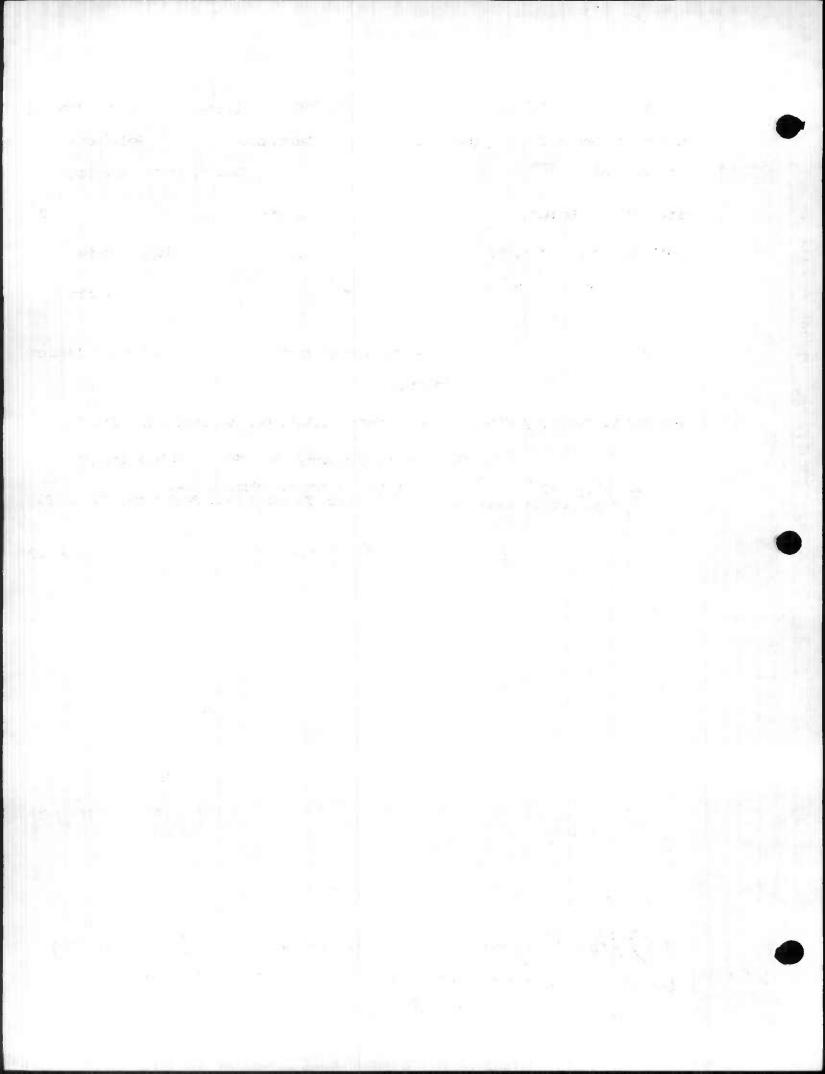
Charles St. Balto, md 6 BMC 6701 N. 32. Registrar's Signature

t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner stated.

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) Day **Physician** ELLA 0200 GLICK 25 1999 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Baltimore N If Undar 24 Hrs. Hours Min. Hours Min. Baltimore N 8. Data of Birth (Month, Day, Year) FEB. 2, 1913 Univ. of Maryland Medical System

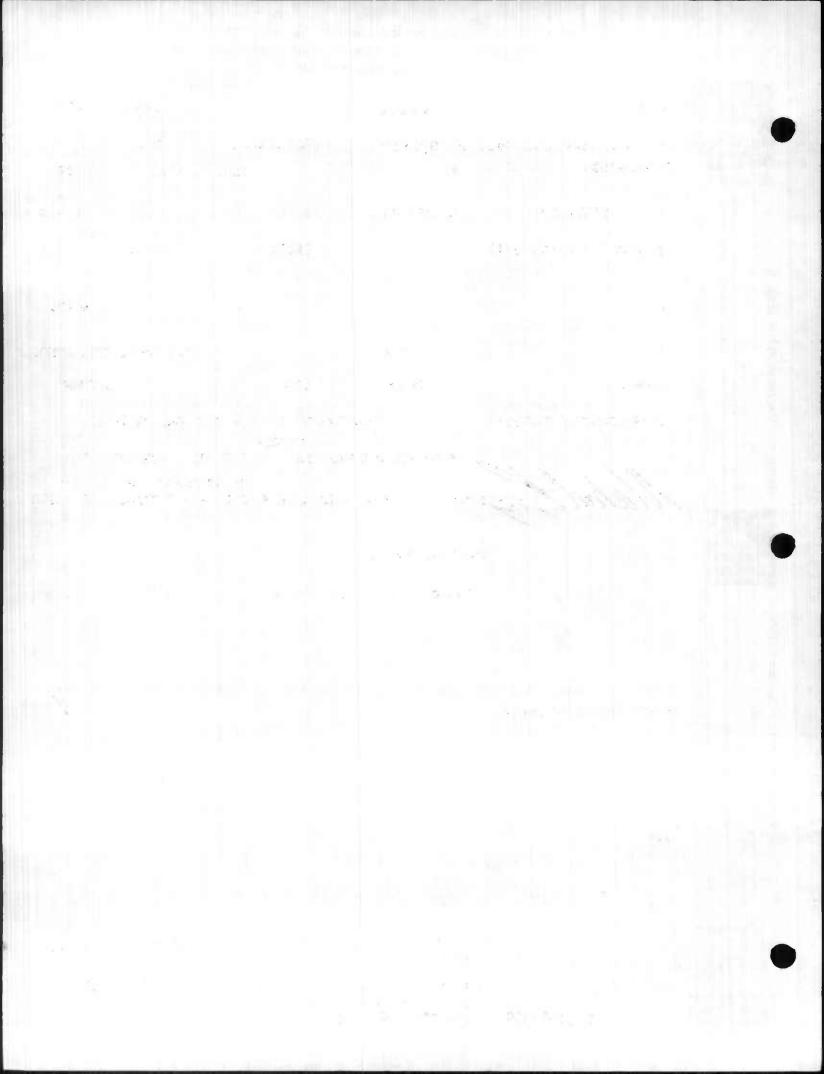
5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) H Under 1 Year Birthplaca (State or Foreign Country) **Funeral** Months 1□ M 2K F Days 215-28-1589 86 MD Director Usual Rasidanca of Dacedant 10c City Town or Location 10d. Insida City Limits 10a Stata 10h County notified at MD BALTTMORE BALTIMORE 1 ☐ Yas 2X No Director 2 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or items 23a or the Medical Examinar must be r 16 OLD COURT ROAD #412 21208 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien. 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ WHITE Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) College (1-4or 5+) Elemantary/Secondary (0-12) Hyglene. CLERK BALTIMORE CITY SCHOOLS Pages 1 and 2 should be filed w timent of Health and Mental Hygler start: If Item 27 is marked other it ijury or other traumatic event, ID. 17 Fathar's Nama (First Middle Last) 18 Mothar's Nama (First, Middla, Maiden Sumama) Be MORRIS CHERNOW LENA BRISKMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) REHA LONDON / DAUGHTER 2341 PROVIDENCE AVENUE - CHESTER, PA 19013 20b. Placa of Disposition (Nama of cametery, cramatory or other placa) CIRCLE 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of important: If 8/27/99 5 Other (Specify) BOBROISKER BENEFICIAL ROSEDALE, MD 4 Donation At Emeral Service Lig 22 Nama and Addrass of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final Cardiac Arrest disease or condition rasulting in death) Examiner Dua to (or as a consaquanca of): Examiner Ruptured Thoracic Aorta physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that Initiated evants rasulting in daath) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 80 esn. ŏ signed by the aid be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Parkinson's Disease þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 2 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Placa of Death (Check only one) axaminer? Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 20 No 2 1 Yes 1 Inpatiant 2 ER/Outpatient 3 DOA this the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of Certification: After 5 Pending Investigation Natural death. 1 ☐ Yas 2 ☐ No 2 Accident efter death 3 ☐ Sulcida 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowladge, daath occurred at the tima, data and place, and dua to the causa(s) and manner as stated.

Medical Examinar: On the best of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner statad. 29a. Cartifian edicai (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifian P12456 30. Nama and addrass of parson who complated causa of plath (Itam 23a) (Type, Print) LISA NIPKOW South Greene Street Baltimore, MD

Registrar

31. Data filed (Month, Day, Year)

32. Registrer's Signature



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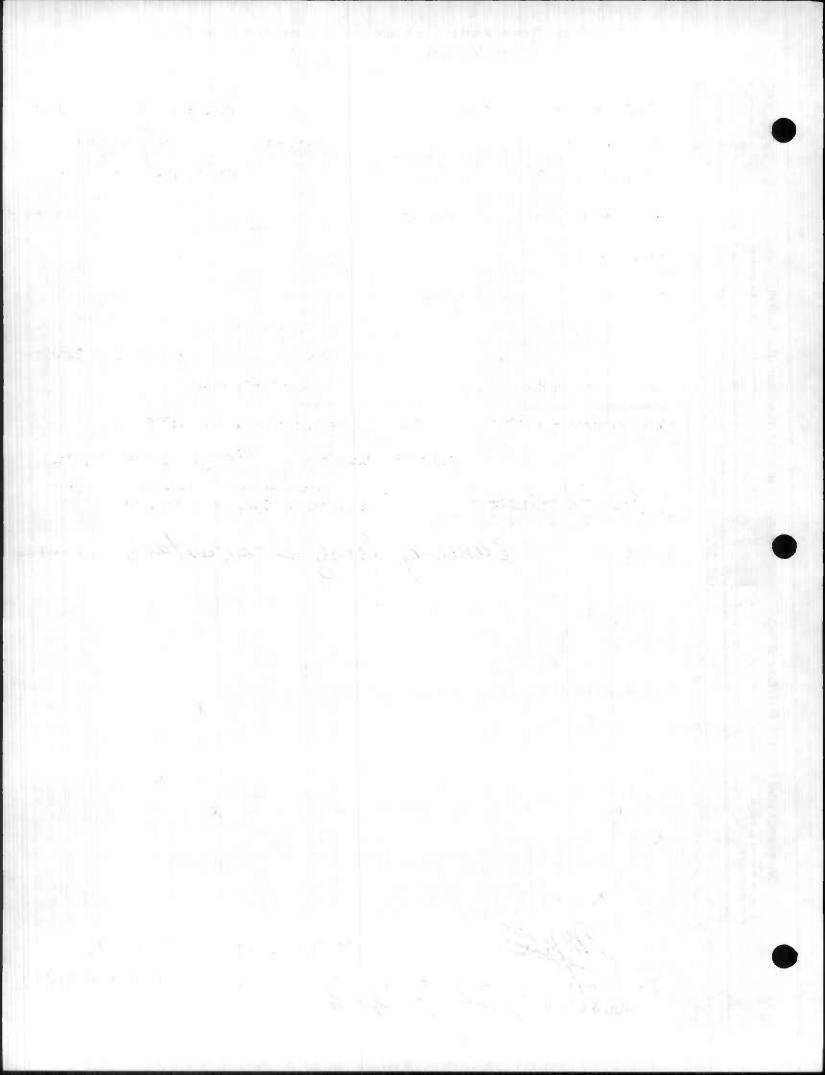
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_			AUGUSTIN CHYU, M	.D., VA MEDICAL C	CENTER, FORT	HOWARD, M	RYLAND	21052								
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** 27 1334 4c. County of Death Richard Stanley Hood AUG. 1:30 AM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) Examiner 7509 Race Road Arundel Hanover If Under 1 Year | If Under 24 Hrs Months Devs Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 □ F Deys 70 Director 218-26-5800 MAY 8, 1929 Maryland Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Manyland neat of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23s or 28e-f show unt; If Item 27 Is marked other than "natural", or other thannal be notified all uny or other thaumatic avent, the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Hanover 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7509 Race Road 21076 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American Indien. Bleck, White, etc. 1 □Wes 2□No
If Yes, Give Korean
Year or Dates: Confli 1 X Never Merried 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Conflict Completed 16a. Decedant's Usual Occupation
(Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elemantary/Secondary (0-12) 12 Mail Clerk Bank of Glen Burnie 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Louis Anderson Hood Anna Marie Hinks 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louis A. Hood - brother 7517 Race Road, Hanover, Md. 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20e. Method of Disposition important: If it eny injury or o pnce. 8/30/99 1 D∕Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Glen Burnie, Md. 22. Name and Address of Fecility 21. Signature of Funeral Service Moenses Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. shock, or heart failure. List only one cause on each lina. Approximate Intervel Between Onset and Death **Physician** Cancer of lling I mutastard /Medical Immediata Causa (Final o month disease or condition resulting in death) Examine Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 980 o signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 10 Yee 2 No 3 Probably 4 Unknown Š 24b. Ware autopsy findings available prior to should I Completed 24a. Was en autopsy performad? completion of ceuse of death? s certificate has t 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: director Be 25. Was casa raferred to medicel examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 200 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour.
Se Funeral Dir.
Se filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred et the time, date and place, and dua to tha ceusa(s) and menner as stated.
2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to tha causa(s) and manner stated. 29a. Cartifian edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of MD D26294 who completed ceuse of daeth (Item 23a) (Type, Print) majden Chice Lane, Balto, MD 21229 mD, 1101 Zuniga 32. Registraris Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Harrison 139 Set4 0047 AVG 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Huspita L BALTIMORE Gar SAMaritan N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 200 F 75 217-16-3699 Director Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar mast be not many enter. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1651 East Belvedere Ave. United States Apt. 209 Funeral 12. Was Decedent Ever in U,S.
Armed Forcas?
1 ☐ Yes 2 [X] No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ρ Specify: White 3 M Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Clothing 8 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John J. Pagano Wells Virginia 19a. tntormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Kennard Avenue Sharon M. Miller - Niece Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/99 Baltimore, Maryland Baltimore National Cem. 21. Signature of Funeral Service Licenses Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road ridde LEONARD J. RUCK, INC. 21214 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final rrythmia Bradycardia disease or condition resulting in death) Examiner Examiner XEMTA physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, STIVE HearT FAILURE Physician/Medical the at be Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yea 2 No 3 Probably 4 Unknown Regues, taTion 2 Completed 24a. Was an autopsy performed? 24b. Wera autopsy tindings available prior to peed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certifications. funeral director, 25. Was case reterred to medical axaminer? 26. Place of Death (Check only one) Be To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (I Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atterview within 24 hours after des To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man

State Registrar

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32. Apgistrar's Signature

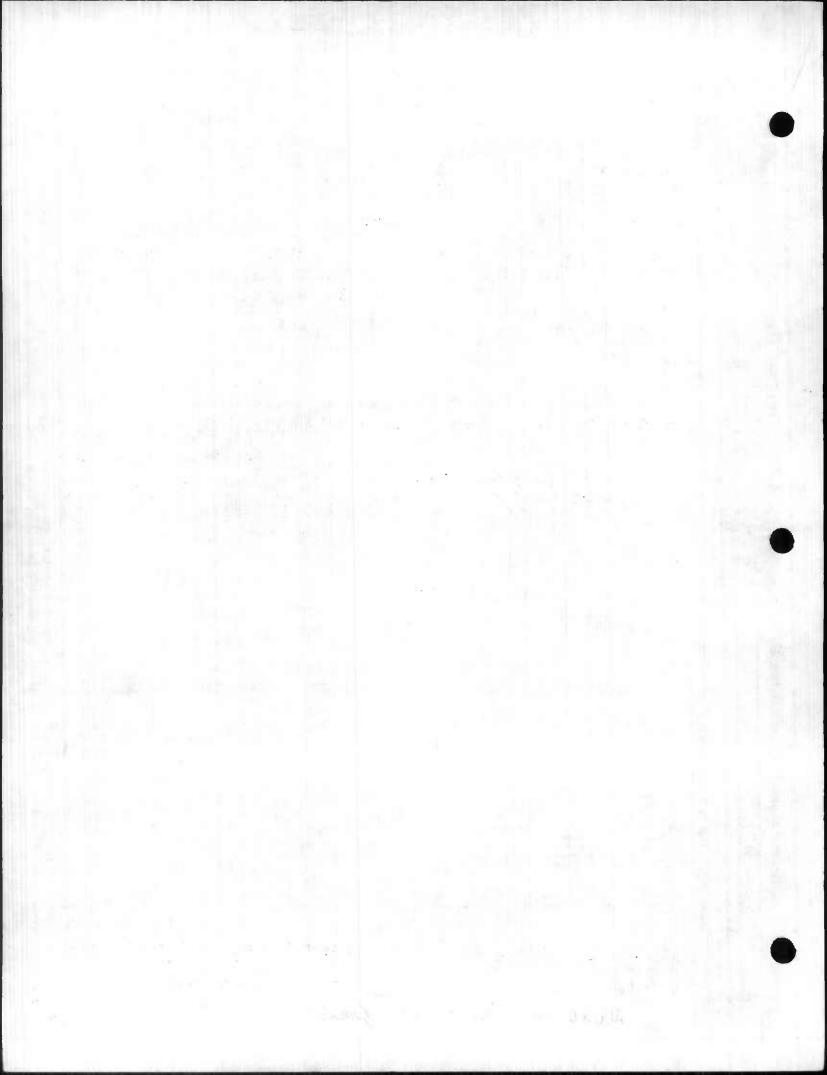
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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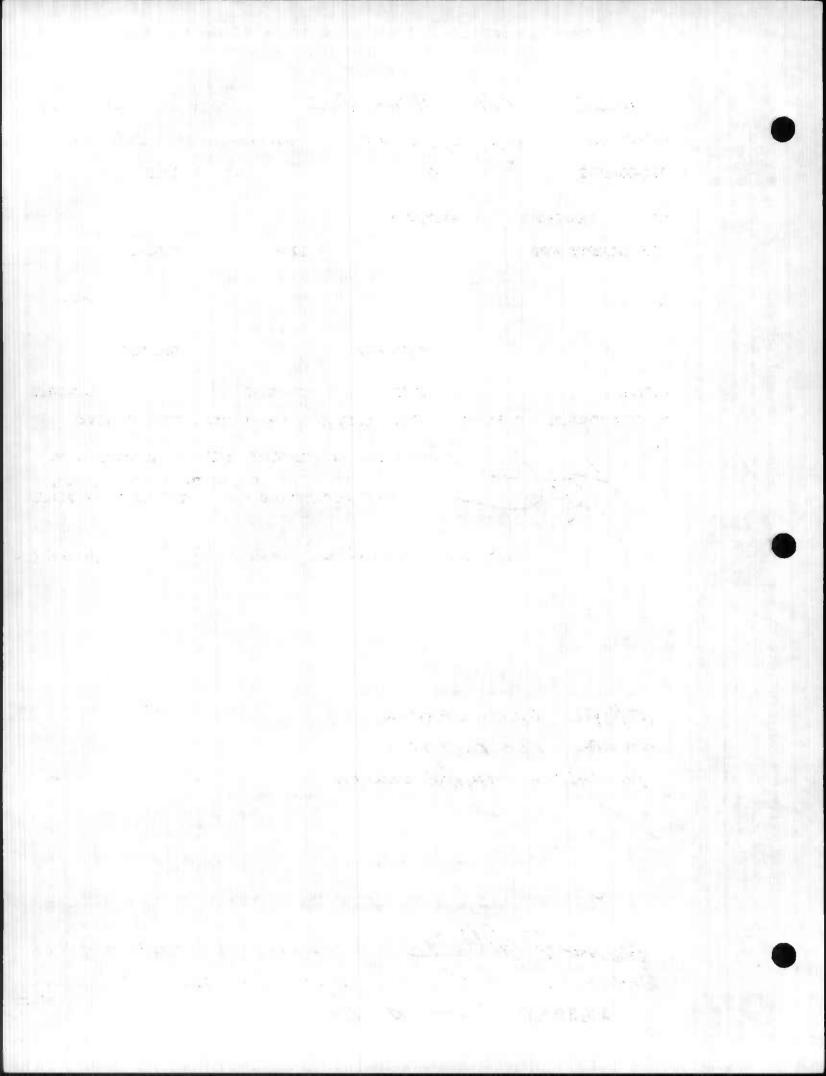
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) HENRIQUES **Physician** ERNA 120SE AUGUCT 25 /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner RANDALLSONOUN OKTHUCES BACTIMORE CENTER HOSKITAL 7. Aga (In yrs. last birthday) If Undar 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex Funeral 1□M 2XF Months Days Hours Yrs. 214-03-1812 83 NOV. 2, 1915 **Director** Usual Rasidance of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rail, or items 23s or 28s-f shov Examiner must be notified at 1 ☐ Yas 2√ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7801 LIBERTY ROAD 21244 U.S.A. Peges 1 end 2 should be filed within 72 hours after death nent of Health end Mentel Hygiene. Int: If item 27 is marked other then "natural", or items 23. Funerai 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 [X]No If Yas, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puarto Rican, etc.) 14. Reca - American Indian. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed The Medical 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) **JOSEPH** CAROLINE OSNOWITZ. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERTA STRAUSS / DAUGHTER 320 EUCLID AVENUE - MICHIGAN CITY, IN 46360 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Department of important: If its any injury or o 1 Burial 2 Cramation 3 Ramovai from Stata HEBREW FRIENDSHIP CEMETERY 8/27/99 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Qthar (Specify) 21. Signatura of Fungal Bankly 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Caura (Final diseasa or condition resulting in daily) /Medical GASTROINTESTINAL BLEEDING MINUTES Examiner Dua to (or as a consequence of) Examiner attending physician end for use es the bunal-transit Sequentially list conditions, if any, laading to Immadiata cause. Enter Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the death certificate be Physician/Medicai that initiated avants rasulting in death) Last Due to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a signed by t 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION The law requires thet þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed REGULGITATION page 2 1 Yes 2 No certificate or Attending Physician: 25. Was cesa rafarrad to medicei axaminar? director Be 26. Placa of Daath (Check only one) Hospitai: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Impatiant 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) funeral 28d. Dascribe how Injury occurred 27. Manner of Deeth 28c. Injury at Work? Certification: 28b. Time of After 5 Panding Invastigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Funeral Director:) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicida hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 29a. Cartifier Medicai completely (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manuerstated. 24 within 2 To the 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Dav. Year) D22/15 30. Nama and address of person who completed ceusa of death (ttam 23a) (Type, Print) BATIMORE, MI 8600 LIBERTY RD. JBIN BEKNANS 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature State AUG 3 0 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #19bPPER FH G775 9/2/99 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ERNEST /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** RIGHTON If Under 24 Hrs. If Under 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 9. Birthpiace (State or Foreign **Funeral** Months Days Hours 1 MM 2□ F Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Norms 23a ON Funeral 12. Wes Decedent Ever
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 11. Marital Status 13. Was Dec American Indian Black, White, etc. should be filed within 72 hours after of Mental Hygiene.
marked other than "natural", or ite 1 Never Married 2 Married 1 □ Yes 2 2 100 Baltimore, Maryland 21215-0020 Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygh Important: If Itam 27 is marked any Injury or other terminals. 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARE AMOS 3035 BRIGHTON STREET 20b. Place of Disposition (Nar cometery, crematory or o 20a. Method of Disposition nsition (Name of matory or other place) 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4019 23a. Part1. Enter the disease, or complications that fause shock, or heart feilure. List only one cause on each li Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Metastatic physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): 980 P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, þ The law requires 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? page 2 s 1 Yes 22(No 1 ☐ Yes 2 No No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Attending 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attandit within 24 hours after death. To the Funeral Director: At 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70 30115

State Registrar

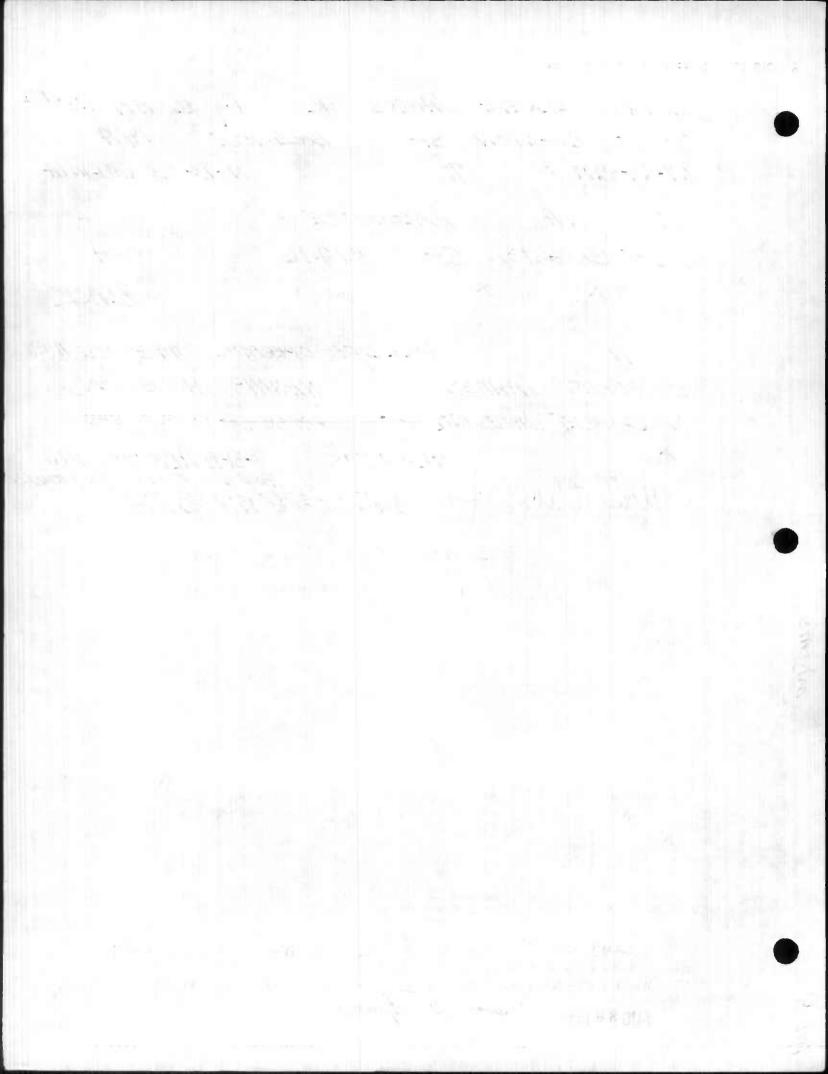
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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ohiokpelai, mo 2600 LIBERTY HOTS /32. Registrar's Signatur

B911.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Dey RINISE LYNETTA 08 99 26 10:15 A.N. 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 30 BM If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month) Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sex Months Deys Hours Min. 1□M 2 F 215-68-7436 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Ma 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2100 886 5. 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bieck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretair WORK YRARS 17. Fether's Neme (First, Middle, Last) 18. Mother'a Neme (First, Middle, Meiden Surname) JAMes 91 white 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Jones J050 20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Suriei 2 ☐ Cremetion 3 ☐ Removel from State MEN. Cene, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility uld 2121 57 'Arol R Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) ENTRICULAR ARRIYTHMIA MINUTES Due to (or es a consequence of): ARDIONYOPATHY 20 YEARS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): ONGENITAL CORONARY MATERY ANOMALY Due to (or es e consequence of): Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 No 3 Probably 4 Unknown DIABETES 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 2 No 1 ☐ Yes 2 No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 28c. Injury et Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

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Be Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes 20 No

27. Menner of Deeth 1 Neturel 2 Accident 5 Pending investigation

3 Suicide 6 Could not be determined 4 Homicide

28e. Dete of Injury (Month, Dey Year) 28b. Time of

Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28d. Describe how injury occurred 2 No

Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier

AUG 3 0 1999

29c. License number 037304

1 Yes

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

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31. Dete filed (Month, Dey, Year) Registrar

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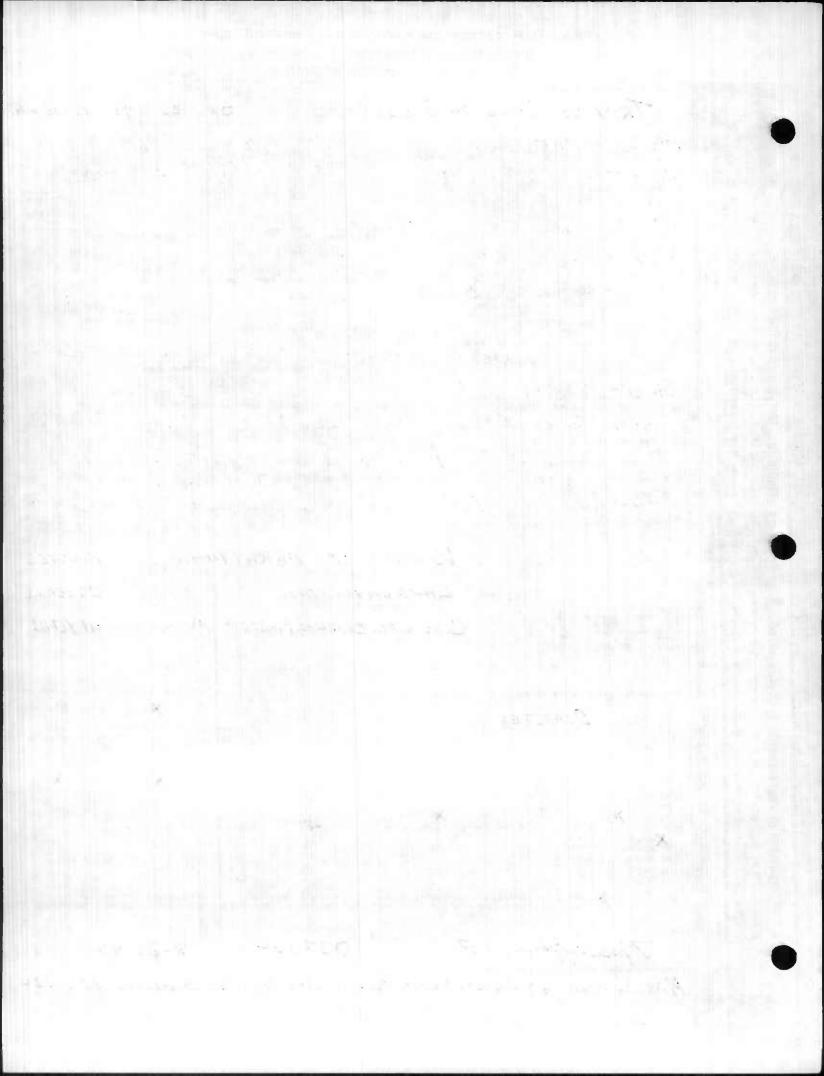
29e. Certifier

MARC SHIFFMAN, M.D. LINDECO HEALTH CENTER 2809 BOSZONS & BANTIMONE MD 21224

DHMH 16 Rev 6/95

24 hours a

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month. Day Year IVORY V. JOHNSON 8 1999 0 32 a.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cahill Court Wood lawn Baltimore If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2OXF Months 214-38-9208 57 **Director** Md Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Mexical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Balto Md Woodlawn 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6512 Woodgreen Circle 21207 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☑ Merried altimore, Maryland 21215-0020 **Black** 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene. Important: if feen 27 is marked other than "na any injury or other traumatic evant security." Deaton Specialty College (1-4or 5+) N/A intery/Secondery (0-12) 10th grade Nurse 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 Wallace Brock Lula Mae Rogers 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Arthur Johnson - Husband 6512 Woodgreen Circle Woodlawn, Md 21207 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 8-28-99 Catonsville, Md 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 20 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Affer Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident after deati Director: 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homleide within 24 hours a To the Funeral C completely filled Hospital 29e, Certifier 11/ Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. To the 29b. Signeture and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) My 30 Name angleddress of person who completed cause of deeth (Item 23a) (Type, Print)

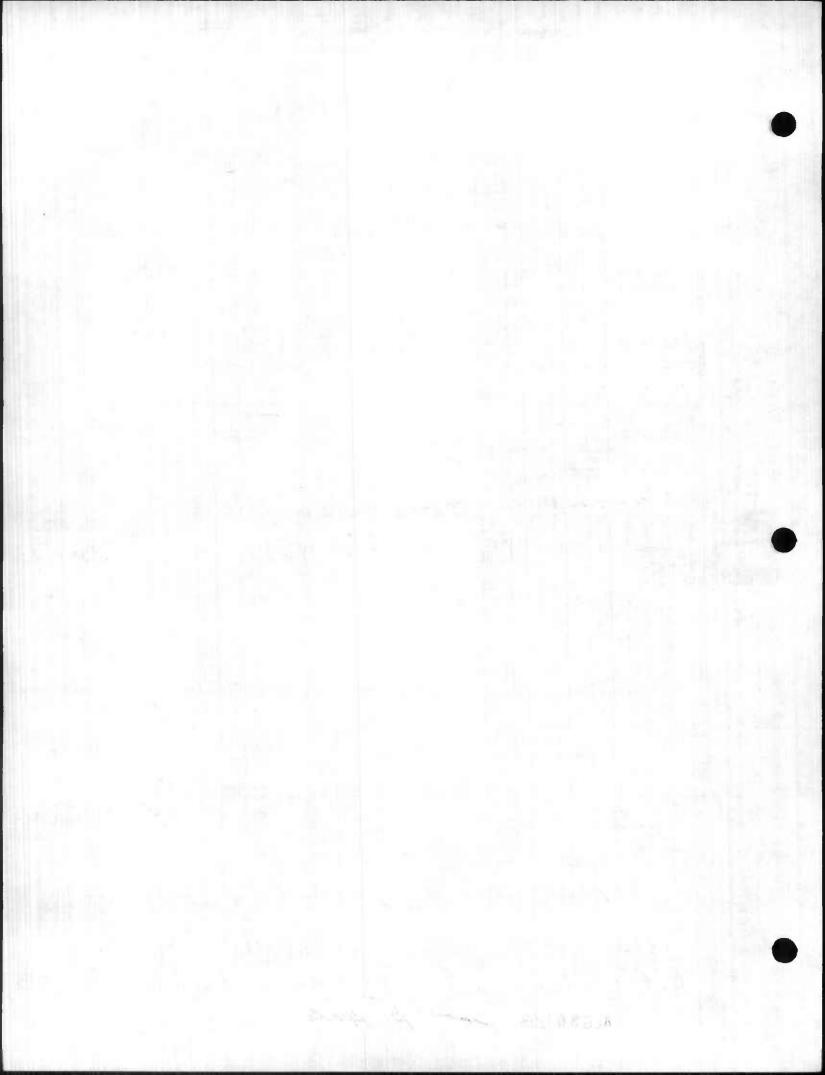
State Registrar

31. Dete filed (Month, Day, Year)

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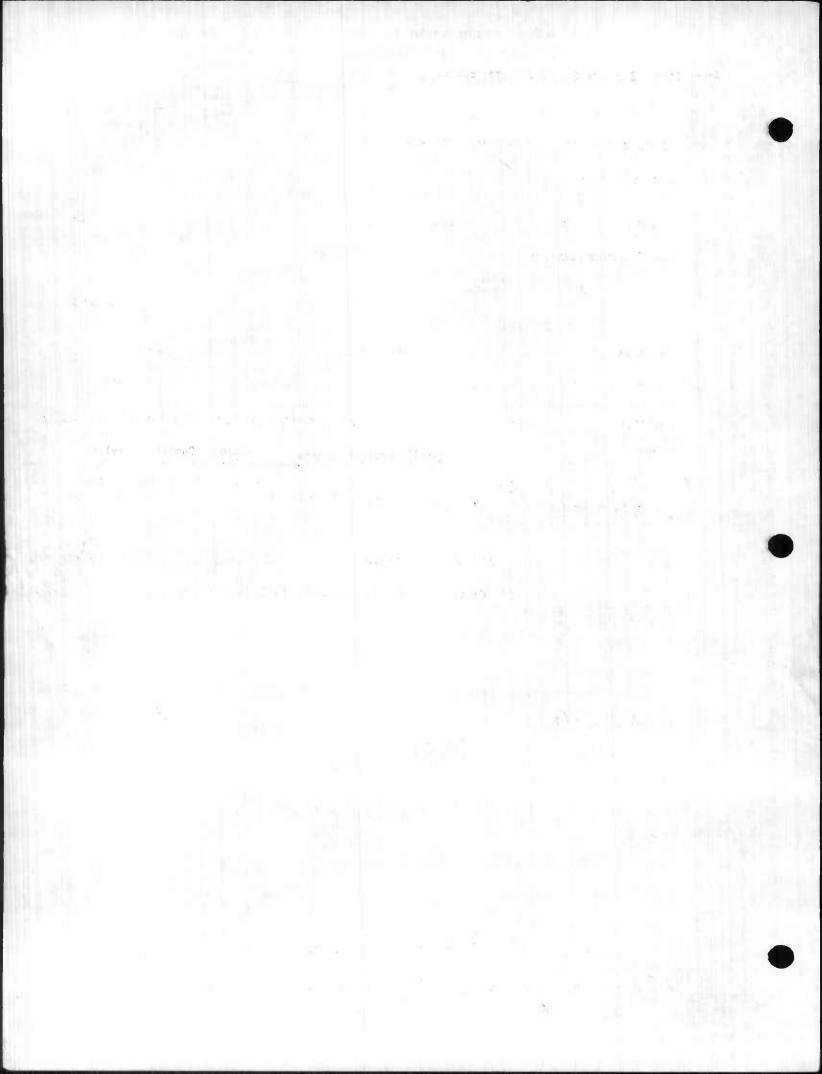
32. Registrer's Signeture



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DHMH 16 Rev 6/95



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RONALD **JACKSON** State of Maryland

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Certificate of Death	Photo Alexander	-	67	Tuello I			

	Physician
	/Medical
A.	Examiner

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b

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

altimore, Maryland 21215-0020

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ronald Allen Jackson 23, 1999 AUGUST 7:42P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE

21216

Funeral Director

Director

Funeral

þ

Completed

Be

2

If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 6~1-1945 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 10 M 2□ F 214-40-7038 54

Usual Residence of Decedent 10a. State 7 28a-f show notified at

10b. County 10c. City, Town or Location Md N/A

N/A

1 X Yas 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country?

10e. Street and Number 3612 Springdale Avenue

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Never Married 2 Merried 3 ☐ Widowed 4 X Divorced

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Rece - American Indian, Black, White, etc. specify: Black

Birthplace (State or Foreign Country)

10d Inside City Limits

Md

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Wire Technician

16b. Kind of Business/Industry & P Telephone

USA

17. Father's Name (First, Middle, Last)

Adelaide Powell

John Jackson

19a. Informant's Name/Retationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Adelaide Jackson- Mother 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery Baltimore, Md 21216
20c. Location - City or Town, State

1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)

22. Name and Address of Facility

3612 Springdale Avenue

Baltimore Md

21. Signature of Funeral Service Licensee

wa Ch

March F/H West 4300 Wabash Avenue 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardie shock, or heart failure. List only one cause on each line. Baltimore, Md 21215

8-30-99

Date

18. Mother's Neme (First, Middle, Maiden Sumame)

Physician /Medical Examiner

the burial-transit

page 2 should

funeral director,

certificate

this

After

24 hours after death. • Funeral Director: A

within 2 To the ag.

completely filled in by

Q 8

Be Completed

edicai Certification: To

The law requires that the death certificate be axecuted

P.O. Box 68760.

Division of Vital Records.

or Attending Physician:

Hospital

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Department of Health a Important: If item 27 is any injury or other tra

disease or condition resulting in death) Due to (or es a consequence of):

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or trijury that initiated events resulting in death) Last

Immediate Cause (Final

Due to (or as a consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

1 Yes

24b. Were autopsy tindings available prior to completion of cause of death?

2 No

1 Yas 2 No

25. Was cese referred to medicet 1X Yes 2□ No 27. Menner of Death

1 Alatural

2 Accident

3 Suicide

5 Pending investigation

6 Could not be determined

1 Inpatient 2 XER/OutpatienI 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide 29e. Certifier

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

AUGUST 24,1999

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause de oth (Item 23a) (Type, Print) #50 DONE Mike

111 Penn Street, Baltimore, Maryland 21201

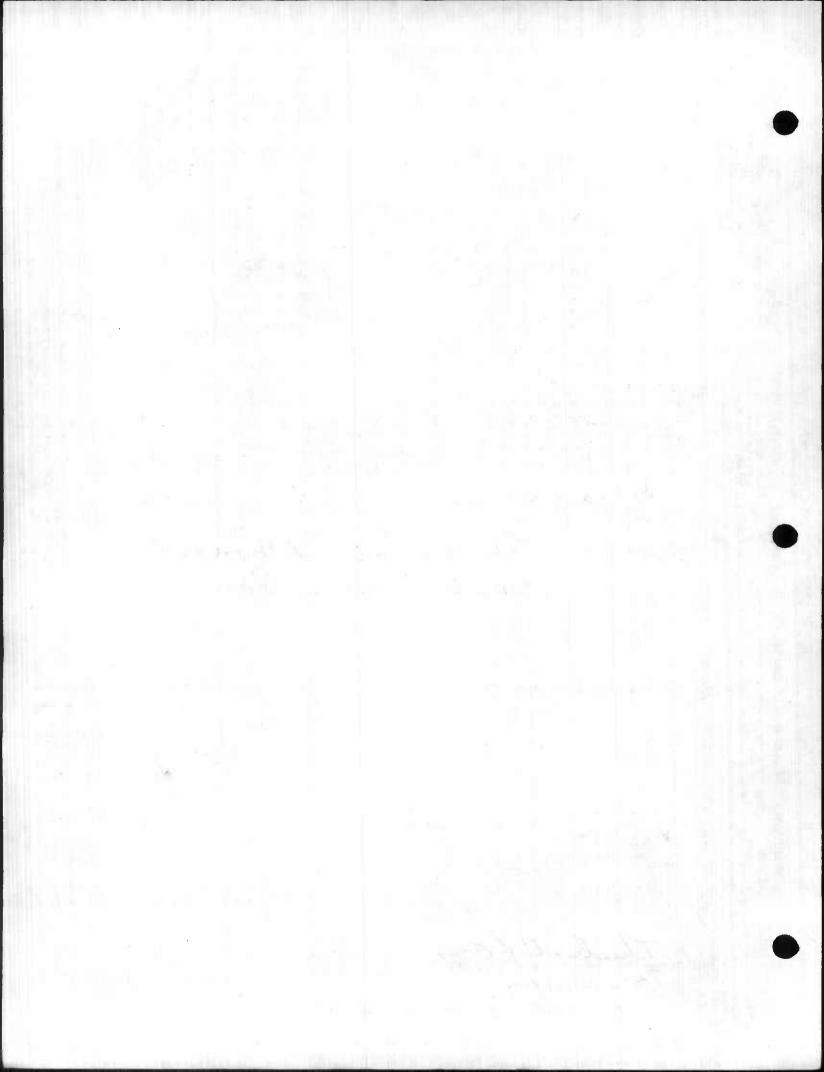
26. Place of Death (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

AUG 3 0 1999

2. Registrer's Signature

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug. 28 Pay 1999 Ronald Emerald Krickler Sr. 5:43 AM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Co. Gen. Hospital Westminster Carroll If Under 24 Hrs. 6. Sex. 1 → M 2 □ F If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Mar Ch 20, 1915 Minnesota 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 84 213-01-8849 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Carroll Manchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3547 Watertank Rd. 21102 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 1. Yes 2 D No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver & Mechanic Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Krickler Ada Olive Dunn 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 3547 Watertank Rd. Manchester, Md. 21102 Virginia Krickler – wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D'Burial 2 Cremetion 3 Removel from Stete LakeView Mem. Park Aug. 31,1999 Sykesville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatury of Funegal Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 26. Place of Deeth (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

Examiner e F Attanding Physician: 24 hours after deat Funeral Director:

Division of Vital

Completed by Physician/Medical Be edical Certification: To

Physician

/Medical

Examiner

Funeral

Director

Show

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Department

Important: If H any injury or o

Physician

/Medical Examiner

Baltimore, Maryland

ERAD

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25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manger of Death 1 Matural

6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

19800

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

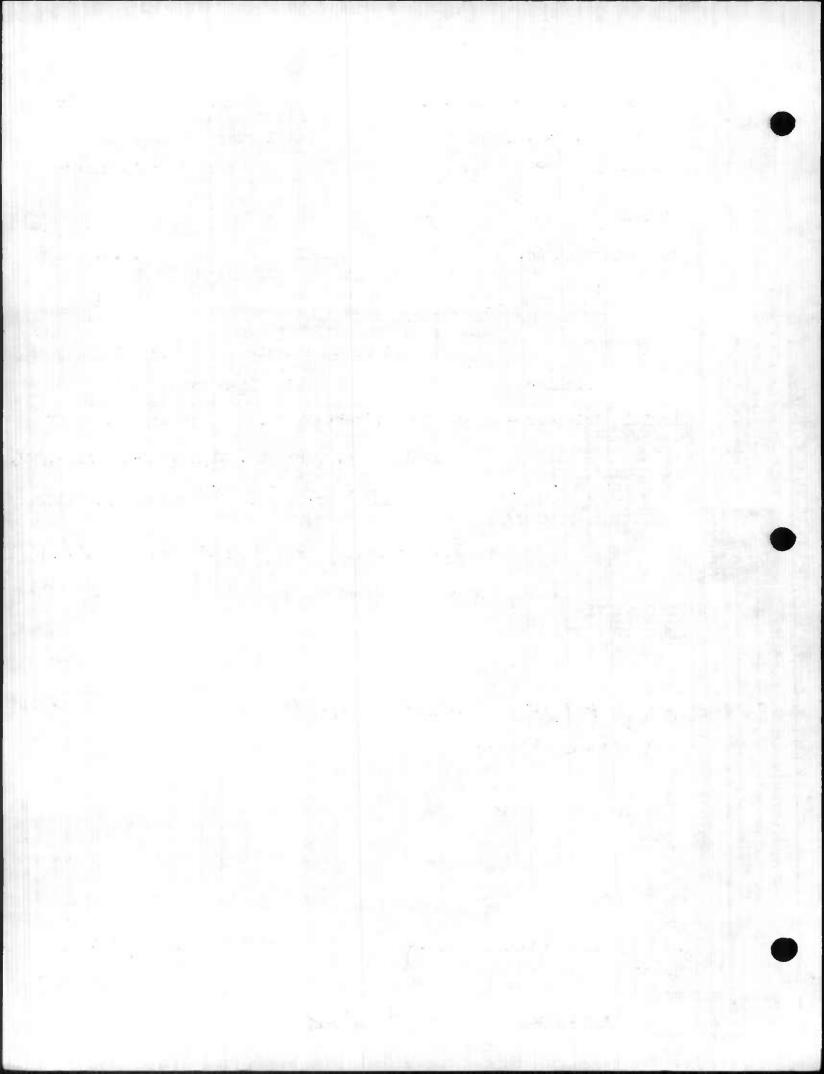
ve, 5-102 Westminster 295 ohn 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

within 2 200

AUG 3 0 1999 DHMH 16 Rev 6/95





Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth 26TH Month **Physician** AUGUST -OCKWOOD 1.36 AM AVID /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. lest birthdey) | If Under 1 Year | Months Days BALTIMORE If Under 24 Hrs. 8. Date of B MARIS 8. Date of Birth (Month, Day, Year) MAY 18, 1959 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** Min. 1 MM 2 F Hours 228-64-472 NORTH CAROLINA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or flems 23a or 28a-f ahor the Medical Examiner must be notified at Yes 2□No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 724 HILL AVENUE 15 A . 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or fren Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ejementary/Secondary (0-12) College (1-4or 5+) 9+# GRADE CLEANING SERVICE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be LOCKWOOD SR. JAMES JOHNNIE BARNES EMMA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6663 WYCOMET WAY APT D. BALTHORE HD - 21234
a of Disposition (Name of Di EMMA LOCKWOOD MOTHER) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removel from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) 5 Other (Specify) METRO 4 Donation CREMATORY BALTIHORE, HARYLAND 22. Name and Address of Facility 21, Sign of Funeral Service Licenses JO, SE PH. FULTON AVE 23a. Pert1. Enter the disease, or complications I'm caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Peritonitin disease or condition resulting in death) Examiner Examiner Appendicent The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Imamode Guerry of Vital Records. by Completed 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes Hospital or Attending Physician: 26. Place of Deeth (Check only one) STELLA MARIS AT MERCY funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division After Netural 5 Pending within 24 hours after death.

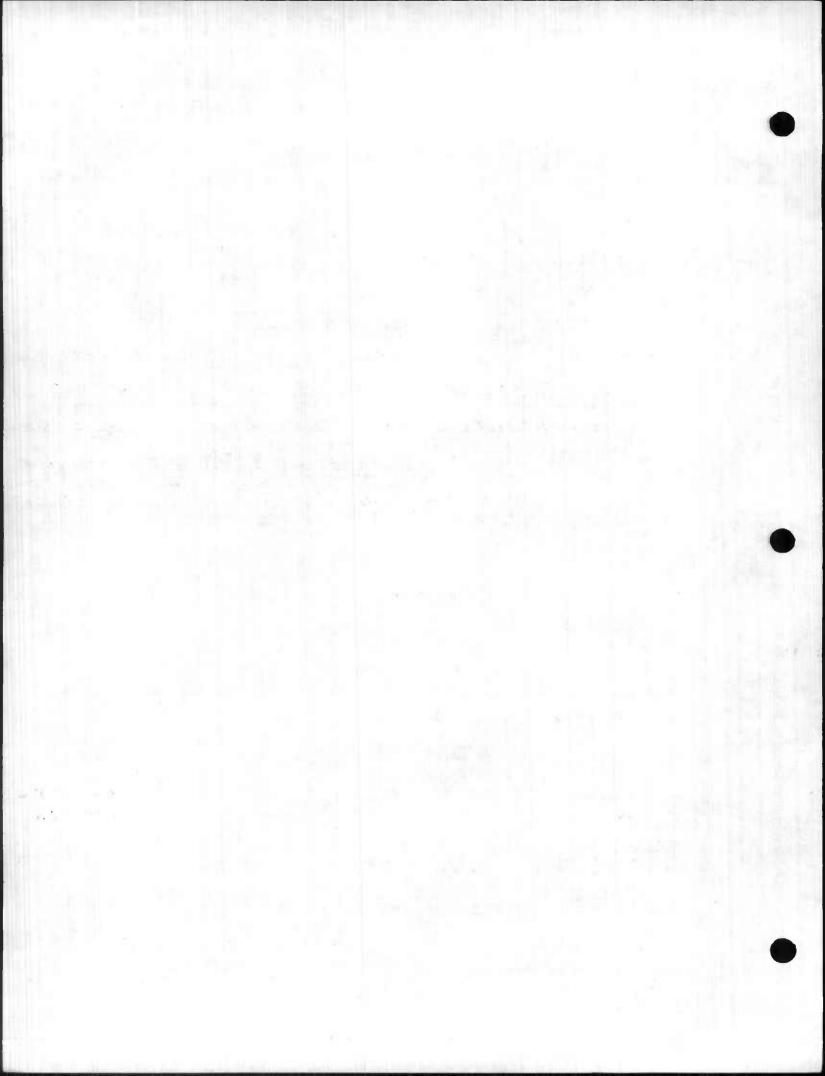
To the Funeral Director: Af 1 Yes 2 No investigetion 2 Accident 6 Could not ba 3 ☐ Suicide 28e. Placa of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D40854 line 8/26/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dank Cisches SO St Print) Bultimor 21227 Rischer 31. Dete filed (Month, Day, Year) 999 State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 ATTICK AULUST 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memoriae BACTIMORE 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4-23-30 5. Social Security Number 9. Birthplece (State or Foreign Country) Days Months 010-24-5972 Usual Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD BACTINCORE BACTIMORE 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21211 516 12. Was Decedent Ever in U,S.
Armed Forces?
1 27 es 2 | No
17 Yes, Give
Yeer or Dates: 47 - 6/ Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritel Stetus Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MAINTENANCE (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LohmAR 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BACT. 516 W. 27 ST. LOHMAR, WIFE MD RMARDI 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 2 A TOME 23a. Party. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequenca of): Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Yes QNo 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Papatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

physician end the buriel-transit 80 signed by t peen : irector, page 2 s Hospital or Attanding Physician: this funeral After within 24 hours efter death.

To the Funeral Director: Af

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

Peges 1 end 2 should be filled within 72 hours effer death with the Marylend nent of Heelth end Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23s or 28s-f abow

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f abov treumstic event, the Modical Examiner must be notified as

permit. Peges Depertment of important: If it any injury or o

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

State Registrar

MULLY 31. Date filed (Month, Day, Year)

29b. Signature and title of

min

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

S. ANCEY WALLOW 3333 Hoth Caluc

32. Registrar's Signature AUG 3 0 1999

and manner stated.

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And the same of the same A CONTRACT OF THE PROPERTY OF parette Man Her Brand on the of you

Please Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:30 PM 08 23 1999 4b. City. Town, or Location of Death 4c. County of Death Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 04/30/1905 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 M 25 F 94 Pennsylvania 10b. County 10c. City, Town or Location 10d Inside City Limits N/A Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zio Code 21214 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: White 16b. Kind of Business/Industry

Physician Violet S. Lehn /Medical 4a Facility Neme (If not institution, give street and number) Examiner Good Samaritan Nursing Home **Funeral** 193-36-1380 Director Usual Residence of Decedent 10a State 28a-f show the Medical Examiner must be notified at MD Director 10e Street and Number 9 3207 White Avenue Nerns 23a Funeral death 11 Marital Status 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or à 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within:
Department of Health and Mental Hygiene.
Important: if hem Z7 is marked other than "n
any injury or other traument. College (1-4or 5+) Elementary/Secondery (0-12) UNKNOWN Organist Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Arnold Shenk Bertha Woodrow 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Lehn/Son 839 Rabitt Lane Reading PA 19606 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Commetery, cremetory or other place)
Balto./Wash. Crematory 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from State 8/27/99 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Dippel Funeral Home Inc. 21. Signature of Ea manut Service License 7110 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel neumonia disease or condition resulting in deeth) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and physician brovascular Records, P.O. Box 68760 Physician/Medical the Due to (or es a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No P

Completed

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of

25. Wes case referred to medical axaminer? Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Neture 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. 29e, Certifier

29b. Signeture and titla of certifie

29c. License number D28987

29d. Date signed (Month, Day, Year)

Approximate Interval Between Onset and Death

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

MD.

CARL SPERLING, M.D. LOCH RAVEN BLUD BALTO, M.D 21239 5601

State Registrar

31. Dete filed (Month, Day, Year) AUG 3 0 1999

32. Registrer's Signeture

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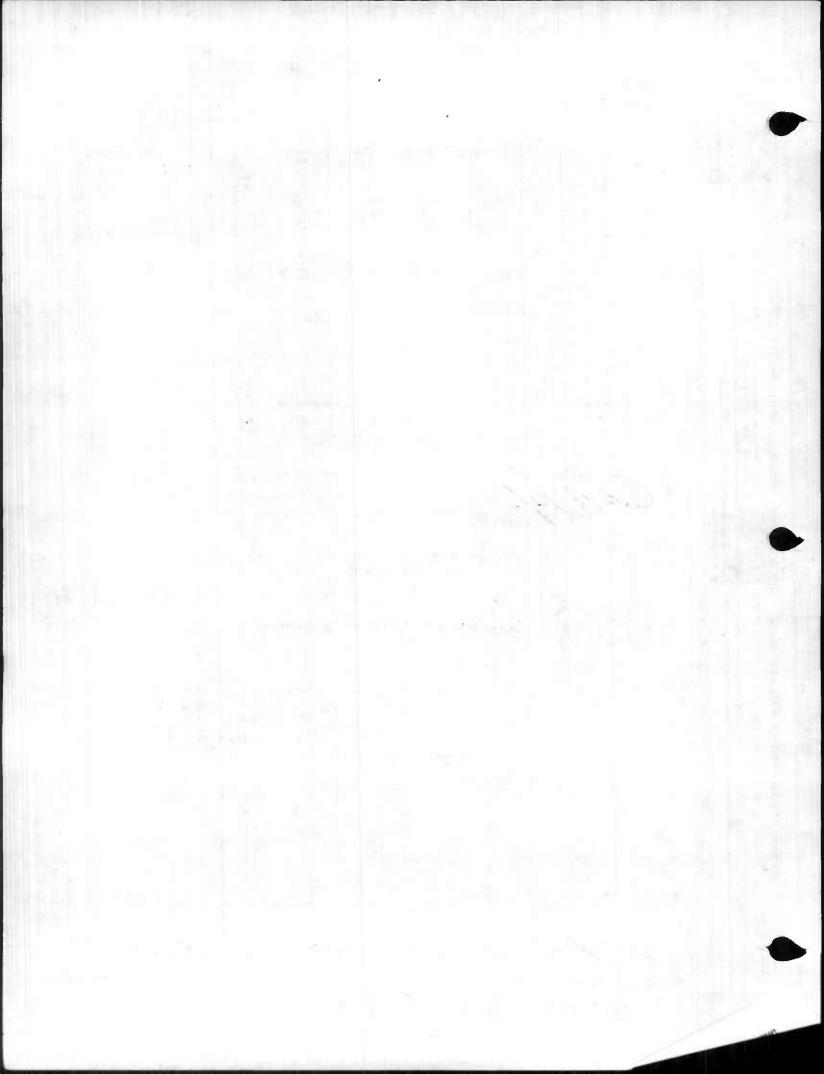
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page 2

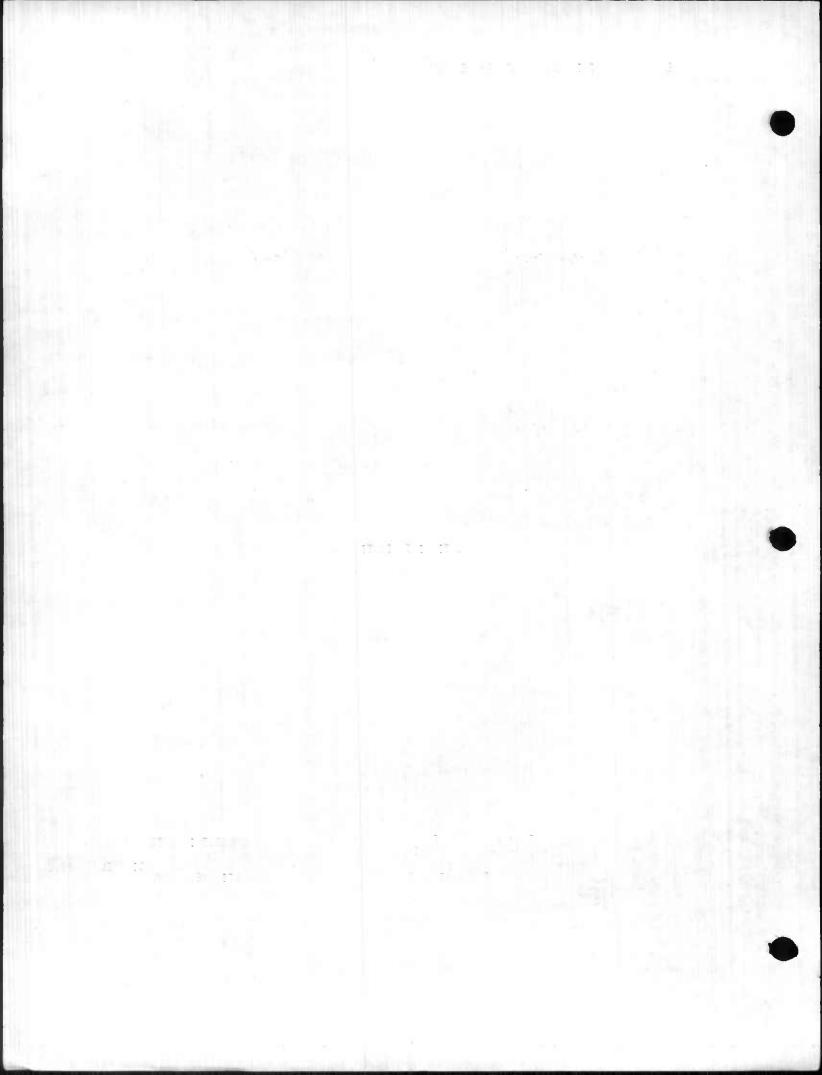
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Medical Certification: To



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Division	or At after of Direct in by	3□ Suicide 6□	Could not be determined	8-28-99 2:15 28e. Plece of Injury - At home, larm, street, fectory, office building, etc. (Specify)						SUBJECT INGESTED DRUGS 281. Location (Street and Number or Rural Route Number, City or Town, State) 2711 SPELMAN RD BALTIMORE, MARYLAND				umber,			
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		30. Name and address of p	5, 12	adent				tre	et, B	altir	nore, l	Maryla	d 212	01			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Joseph G. Mettee 2:55 1999 AUGUST 27 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HGNRS BALTIMORE N/A HEALTHCARE If Under 24 Hrs. If Under 1 Year 8. Date of Birth O Month Bay, Year) 16 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months XIXM 2DF 82 Yrs. 03 3162 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Catonsville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 227 Osborne Ave. 21228 IISA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Tyes 2 No Il-Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 Byes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Interstate Commerce Comm. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis A. Mettee Marie L. (Ball) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) patricia Mettee/Wife Osborne Ave. Catonsville Md 21228 20h Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Durial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) New Cathedral Cemeter.8/31/99 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ma K- Marshal Sterling-Ashton- schwab Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, S V 1 1 1 e , shock, or heart failure. List only one cause on each line. Approximate 28 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) three wears two months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last TRICUL Due to (or as a consequence of) DISEASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

edical

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a, Certifier

Physician

/Medical

Examiner

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MD

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at

Hygiene.

permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hygient Important: if Item 27 is marked other that any injury or other traumatic avant, That 2008.

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aitimore, Maryland 21215-0020

attending physician and for use as the burial-transit signed l 6 certificata of Vital this

or Attending Physician: After after death. Director: An 24 hou.

Funeral Div.

filled in by To the Hosp within 24 ho To the Fune completely fi

Registrar

SAFREN JONATHAN mo 31. Date filed (Month, Day,

investigation

6 ☐ Could not be determined

3449 WILKENS 32. Registrar's Signature

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARYLAND DOOY1711 AUGUST ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVENUE SUITE 300 BALTIMORE, MARYLAND 21229

AUG 3 0 1999

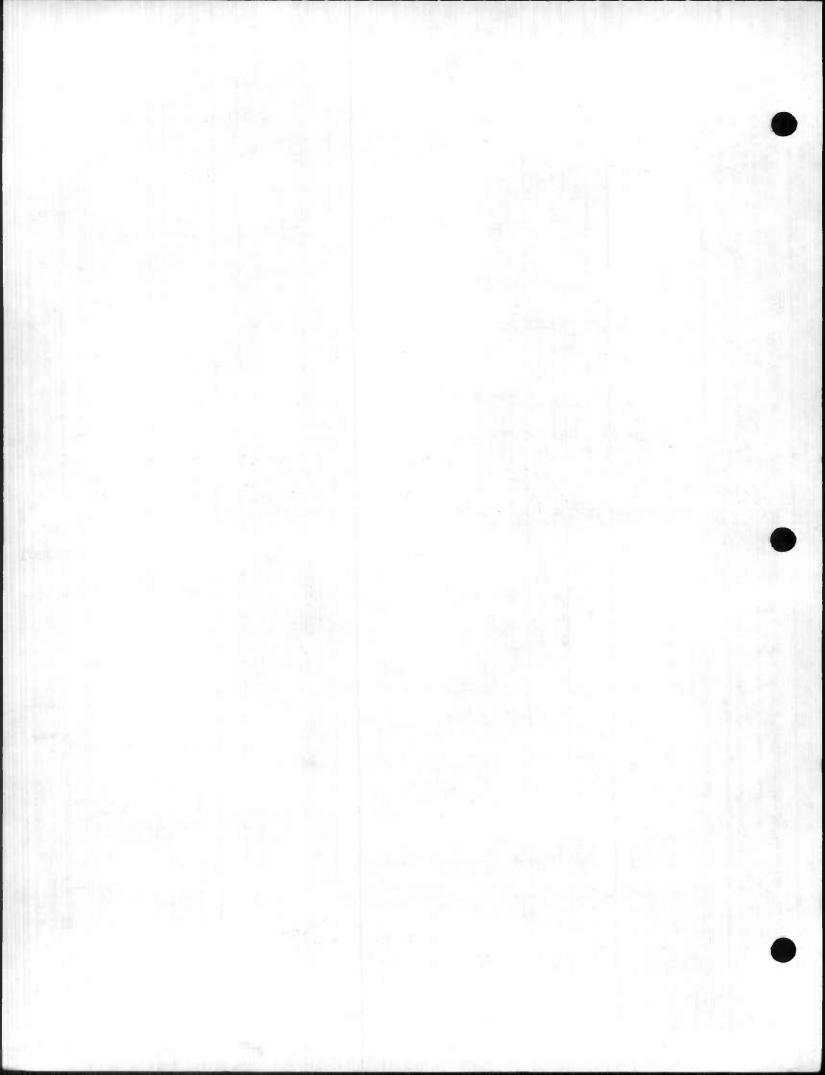
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death Year **Physician** Miles August 1435 Berniece 244 1977 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctn. Baltimore 7. Aga (In yrs. last birthdey) If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 1 M 2 TF Months 219-12-5146 Director MD Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahon mant be notified at 1 Yas 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1933 Haselmere Road 21222 USA Rems 23a Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglena. Infortant: if Nem 27 le marked other than "natural", or her any follury or other traumatic event, the Medical Examines page. Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Baltimore City Elementary/Secondary (0-12) Collega (1-4or 5+) Custodian School System 8th Grade 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be William Wood Svlvia Cosby 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Janet R. Lewis 1933 Haselmere Road Baltimore, MD 21222 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cramation 3 ☐ Ramoval from Steta 4 ☐ Donation 5 ☐ Othar (Specify) Voshell Mem. Gardens 08-28-99 Dundalk, MD 22. Nama and Addrass of Fecility Baltimore, Maryland 21202 24: Signithwarth Funeral Service Licenses WM.C.March FH 1101 E. North Avenue Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvel Batween Onsat and Death **Physician** /Medical Immediate Causa (Final one week disaasa or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No be det Records. à 24b. Were autopsy findings availeble prior to Completed 24a. Was an autopsy performed? CO Can ce completion of ceuse of death? 1 Yas 200No 1 ☐ Yas 2 ☐ No 25. Was cese rafarred to medical axaminar? Division of Vitai To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director; to Be 26. Placa of Death (Check only ona) Hospital: 1 Yas 20 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of fnjury 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Phyeician: To the best of my knowledge, deeth occurred et tha time, deta and place, and dua to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of exemination and/or invastigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier Medical (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Dey, Year) 30. Nama and addrass of parson who completed ceuse of death (Item 23a) (Type, Print) Hopkins Boyview Medial Center Im. Yas De 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 1900 AUG 30 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 1845 Baymond 4b. City, Town, or Location of Deeth · /Medical 4a Facility Name (If not institution, give street end num 4c. County of Deeth **Examiner** Medica Baltimore more City Viercy If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey. Birthplece (State or Fareign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 10 M 20 F Months Yrs. 216-01-054 UNKNOUN 0 Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BACTIMORE 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21201 AUL Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritei Status 1 | Yes 2 | No If Yes, Give Yeer or Detes: 41 KNOWN Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Unknown UNKNOWN UNKNOWN 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) UNKNOWN unknown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Reletionship (Type, Print) BACT, MD 210 20c. Location - City or Town, State Med. RECORDS MD 21201 Mery Hosp. 301 ST. ALC 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetery or other place) Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) RENLOVAC 21. Signature of Furgerel Service Licensee 22. Name end Address of Fecility nasonus ralle 23a Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or espiratory errest, shock, or heart failure. List only one cause on each line. tmmediete Ceuse (Finel disease or condition resulting in deeth) MON-SM2 Year Due to (or es e consequence of) Examiner neumania Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert it. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown hypertension 2 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 Ne 25. Wes case referred to medical exeminer? Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Umpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? 5 Pending Investigation 1 Naturei 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Descritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29a. Certifier Medical

Examiner ettending physician end for use as the buriel-transit P.O. signed by Division of Vital Records, Attanding Physician: funeral al or Attending Pi s efter death. 24 hours

Funeral

Director

hem 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avent, it's Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Illingerland if hem 27 is marked other than "natural", or then any injury or other traumatic avant.

Physician /Medical

Saltimore, Maryland 21215-0020

the Merylend

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) State

enc 31. Dete filed (Month, Day, Year)

(Check only one)

29b. Signatury

Mercy mann 32. Registrer's Signeture

Medical

29c. License number

29d. Dete signed (Month, Dey, Year)

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Registrar

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Piease Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** LUIS MUrgA 5:30 Au 160 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery BEHLESDA SUBURBAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F Days 430-45-6188 Months Hours 70 Yrs. Director UNKNOWY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Montgomery Mo 1 Yes 2 No Director BETHEJOA 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 20814 5721 GIOVESNOT UNKNOWIT Funeral 11. Merital Status Chknown 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Armed Forces:

1 Yes 2 No
If Yes, Give
Year or Detes: UNKNOW 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specity: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unknown UNKNOWN UNKChown permit. Pages 1 and 2 should be filed. Department of Heelth and Mental Hygic Important: If ham 27 Is marked other any Injury or other traumatic avant. It 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be UNEROWN Unknowy 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 208/ 4 19a. Informant's Neme/Reletionship (Type, Print) 8600 OLD Georgetour Ro, Bethes DA, MO Suburban HOSPITAL 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Remoyal from Stete 4 □ Donation 5 □ Other (Specify) REMOVA(21. Signalum of Funeral Service Licensee 22. Name and Address of Fecility Anysony Bo. ulle unde Approximate Intervel Between Onset and Deeth Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 Probably 4 thknown 1 Yea 2 No þ Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 20 No 1 Yes 2 No 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No Medical Certification: To 1 Inpatient 2/2/ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Attending 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) n 24 hours efter de le Funeral Diracto pietely filled in by ti 4 Homicide 8 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted. within 2 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

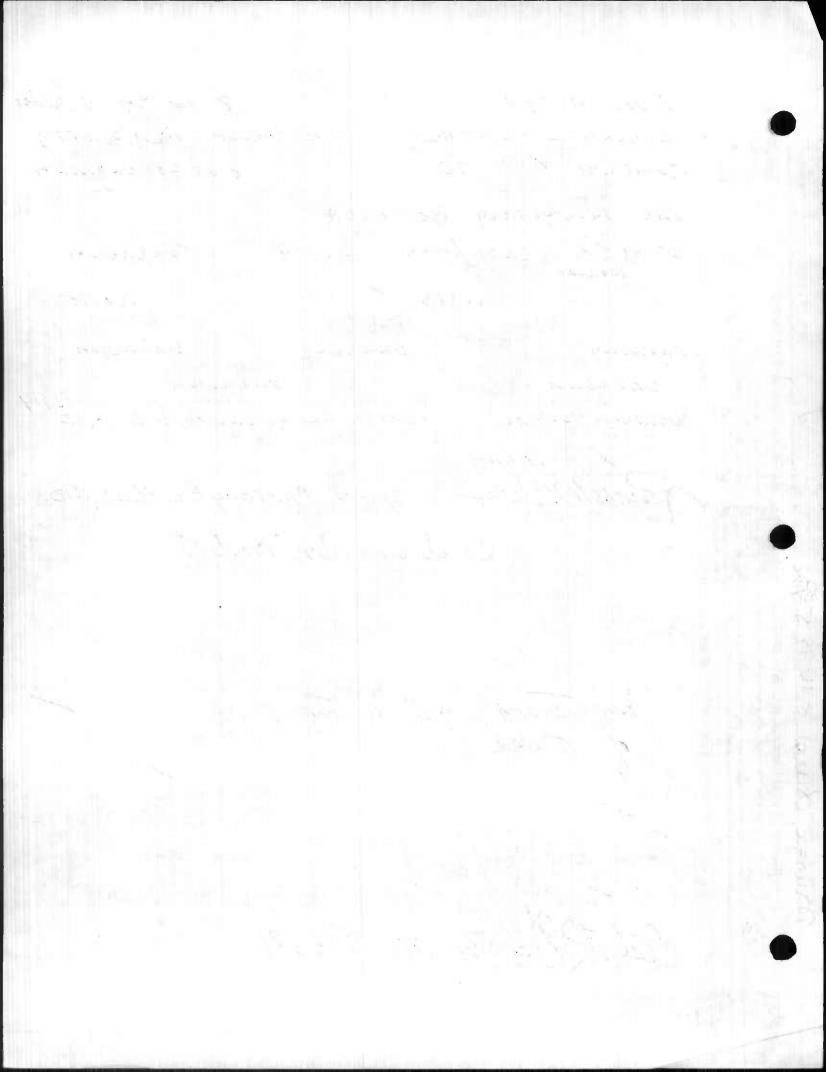
31. Dale filed (Month, Day, Year) AUG 3 0 1999

30. Name and address of po

32. Registrar's Signature oaks

pleted cause of death (Item 23a) (Type, Print)

16.99



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Deeth 3. Time of Death Day Month Mishler **Physician** ELMER 22, 1999 10:20AM August /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** VA Maryland Health Care System

Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Perry Point
If Under 24 Hrs. 8. f Cecil 8. Data of Birth (Month, Day, Year) If Under 9. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number **Funeral** Months Days Hours Min. 12M 2DF 184-09-2011 Director Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r 28a-f show notified at CECIL MD 1 ☐ Yas 2 ☐ No ERRYVILLE Funeral Director MISHLER 2 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? WITH ŏ must be 21903 USA ConCORD 102 DRIVE 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forcas? 1 ✓ Yas 2 ☐ No the state 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. traumetic event, the Medical Examiner Maryland 21215-0020 1 Nevar Married 2 Married If Yas, Giva Yeer or Detes: WW II 8 1 Yes 2 PNo Specify: Specify: WHITE ģ 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) filed within and Mental Hygiene. Is marked other then Elamantary/Secondary (0-12) Collaga (1-4or 5+) "UNSTRUCTION PAINTER 6 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) 8 should be JACOB MISHIER LEED ANNIE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 2160 / Pages 1 and 2 s ment of Health an 1005 WARWICK DA. APT ZB ABERDEEN, MO JOANN SHEHler of Health Item 27 i EXECUTOR Baltimore, 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Department of Important: If it any injury or o pbs. 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stete 4 Donation 5 ☐ Othar (Specify) 21, Signature of Funaral Sarvice Licansea 22. Nama and Addrass of Facility DIRECTOR STATE ANAJOMY BOARS BAIT. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physiclan** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Cardiac arrest unknown Examiner Due to (or as a consequance ot) Physician/Medical Examiner Cardiac arrhythmia unknown The law requires that the deeth certificate be executed ettending physicien and for use as the bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that Initiated evants Dua to (or as a consaquance ot): unknown Coronary artery disease Box 68760, Dua to (or as a consequenca of): rasulting In death) Last P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2□ No 3 Probably 4 Unknown Chronic obstructive pulmonary disease Division of Vital Records, þ 24a. Was an autopsy performed? 24b. Wara autopsy tindings available prior to Completed peen Hypertension completion of causa of daath? 108 page 2 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Othar: Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 2 XNo 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours efter deeth.

Funeral Director: After this rietely filled in by the funeral di 27 Mannar of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury et Work? Certification: 1 XNatural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Sulcide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

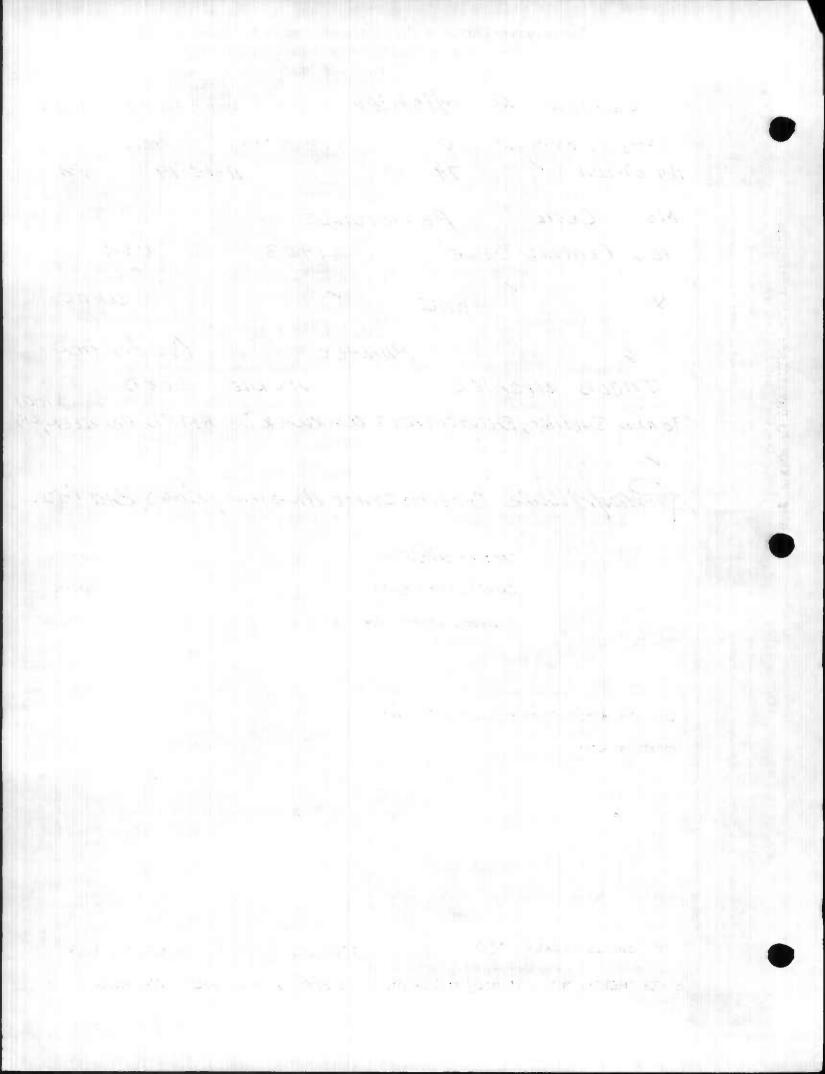
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Cartifier (Check only one) within 2 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) Sami Khewi MD D0052064 August 22, 1999 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) SAMIR KHEIRI, M.D., VA Maryland Health Care System, Perry Point, MD

32. Registrar's Signature

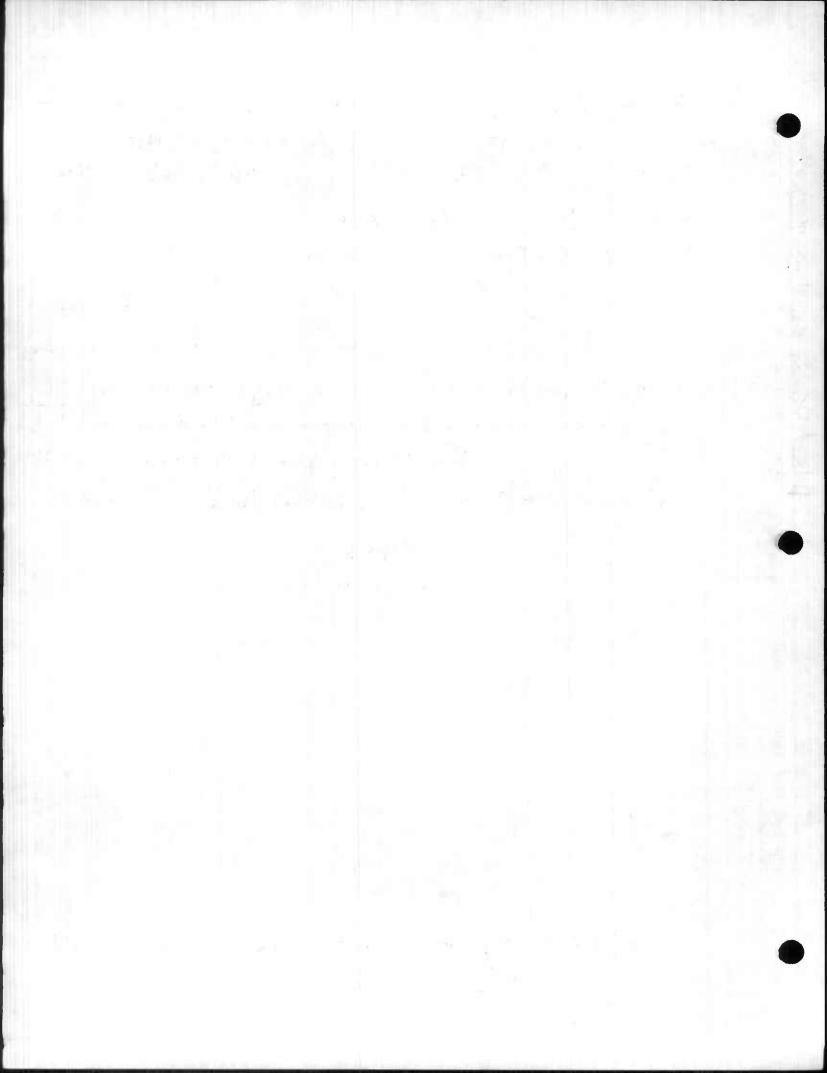
DHMH 16 Rev 6/95

State Registrar

NAME



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Lest) 2. Date of Deeth **Physician** Month Moody HENRY Sanie August 1045 PM /Medicai 4e. Fecility Neme (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DSPI 5. Social Security Number Baltimore NIA 6. Sex 1 AM 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 76 Months Days 213-12-2895 Vrs Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limita Baltimore 1 1 185 2 No NA 289-71 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be WE. 21215 USA IOLE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, event, the Medical Examiner Black, White, etc. 1 □ Never Married 2 □ Married ö 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Wivorced ac 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working kile. DO NOT use retired) 16b. Kind of Business/Industry 0 Elementary/Secondery (0-12) College (1-4or 5+) AIG GHA 100 marked other Maryland Father's Name (First, Middle, Last) 18. Mother's Neme (First, Midelle, Pages 1 and 2 should be Hayes udas 20 N/2 6 1080 706 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number If Ibam 27 Hephanie GOT altimore. 20a. Method of Disposition Town, State b 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) are of Funeral Service Ligansee West Hon narch Funeral Home W 4300 Wabash Ave. Balfo Funcea 21215 Enturing disease, or complications that caused the death. Do not enter her hailure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician /Medical Seps:S tmmediete Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) The law requires that the death certificate be exe Box 68760. Physician/Medical Due to (or as e consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNO 3 Probably 4 Unknown Division of Vital Records, Completed by peq. 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 2200 this certificate or Attending Physician: I or Attending Physician: Director: After this certifica 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 10 1 Yea 20 No Other: 4 Nurstng Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Maturel 2 Accident 1 Yes 2 No filled in by the 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MD 26,1999 30. Name and address of person who completed cause of death (ttem 23e) (Type, Print) King Sina: HOSP. Line 1 31. Date filed (Month, Dev. Year) AUG 3 0 1999 32. Registrer's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Amende Item#23a perPhyG774 8/30/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Walter C. Nooe Sr. 1999 August 22 8:25 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multi Care Center N/A Baltimore 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Months Hours 242 18 4520 Yrs. Director 89 March 4, 1910 North Carolina Usual Residence of Decedent the Meryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at N/A Baltimore 1K Yes 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1302 Pontiac Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indien, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours affer of Department of Health and Mental Hygians. Introcramt: if Nem 27 is marked other than "natural", or hen any injury or other traumatic event, the Medical Expension Black, White, etc. 1 Never Married 25th Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4th McLean Trucking Co. Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Roberta Calicutt Walter J. Nooe 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Nooe Jr. 1554 Long Point Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 9/3/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 234 Part Letter the disease, or compared for sthat caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 4 Y25 RENAL FAILUZE Examiner Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMIOPATHY burial-transit The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Pug physician a Box 68760. ARTERIOSCLEROTIS Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown LECHEM. L CANDO OMY O CATHY Records, by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed ANEM. a RENOR FAILURG has 1 Yes 2 No 1 ☐ Yes 2 No certificata Division of Vital I or Attending Physician: after death. 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending 1 Yes 2 No 2 Accident investigation Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29b. Signature and title of conflict 29c. License number 29d. Date signed (Month, Day, Year) 12399 August 23, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 W. 40 Th ST Didovad is Barnous, m) m.) 21211 KELLICK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 3 0 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 8:30 pm Peter Neubeck Aug. 26, 1999 4e Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 2652 Compass Drive Annapolis, MD Anne-Arundel 8. Date of Birth (Month, Day, Year) Nov. 13, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **★**M 2□ F Months Days 133-12-8774 88 Hours PA Usual Residence of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne-Arundel Annapolis Maryland 1 Yes ANO 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2652 Compass Drive 21401 United States Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedenf Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 10 Yes 2 No 43-46 1 ☐ Never Merried > Married 1 ☐ Yes XX No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Vice President 0 Insurance Co. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First Middle Maiden Surname) John Neubeck Josephine Wesolowska 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aloise Anne Neubeck / Wife 2652 Compass Drive, Annapolis MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta Date 1 ☐ Burial 2 ☐ Cremetion 3 ☑ Removal from Stete Holy Cross Cemetery, Aug. 31, 1999 Lackawanna, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 21. Signeture of Funerel Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore MD 21230 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each least state. Approximate Interval Between Onset and Death Immediete Cause (Finel Conjestive Heart Failure Years disease or condition resulting in deeth) Due to (or es a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of) Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 Probably > CUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 Yes No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home XXXAesidence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 ☐ Pending 1 TYes 2 □ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Attending Physician: The law requires that the death certificate be asscuted burial-transit and Box 68760. physician the 98 for use signed by the a P.O. Division of Vital Records. **Page 2** certificate funeral director. this Affer To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A tha filled in by

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or itema 23a or the Medical Examiner must be

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Department of Important: If any Injury or page.

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed by

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Baltimore, Maryland

29e. Certifier onel

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and tifle of certified 29c. License number 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

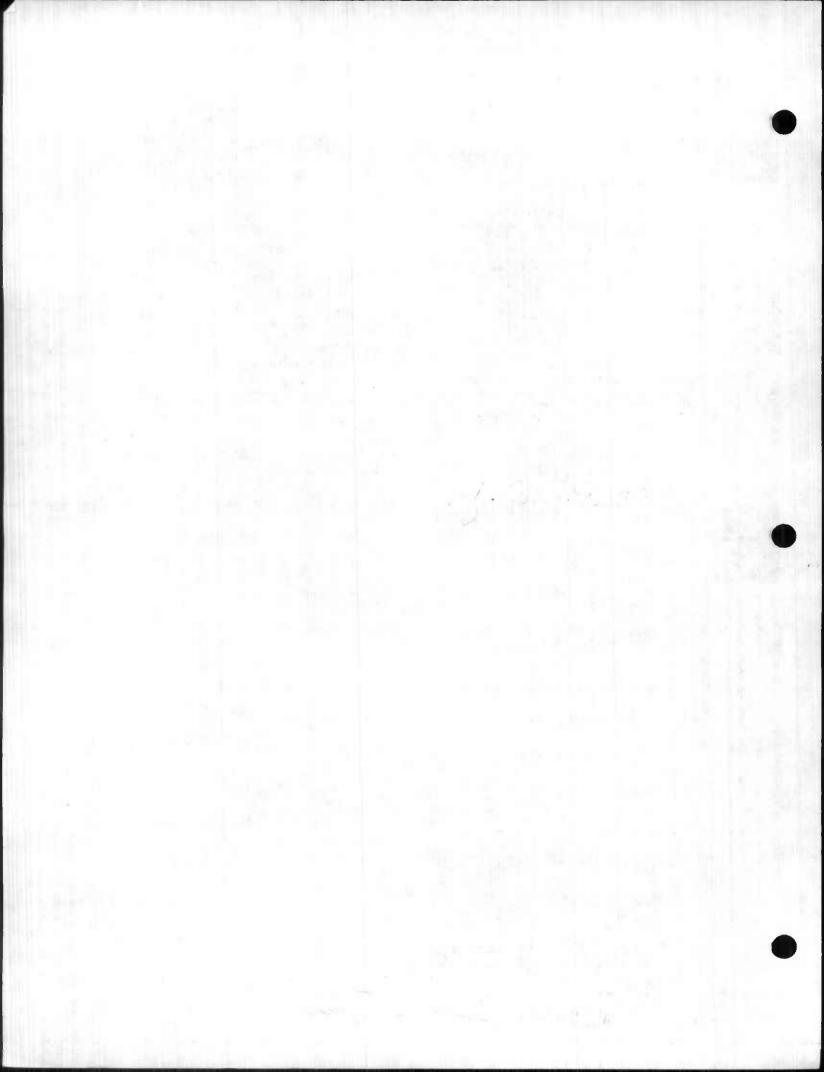
August 27, 1999

2009 Tidewater Coloney Drive, Annapolis Maryland 21401 Jon Lowe,

31. Data filed (Month, Day, Year)

32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) Sally 4b. City, Town, or Location of 4e Facility Neme (If not institution, give street and number) 4c. County of Death Sinai Hospital Baltimore N/A If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 199 16 1666 71 0702 1928 New Jersey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zio Code 2434 West Belevedere Ave. 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Edward Sosinski Alexandria Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Helen Barron-Sister 2351 Bowman Ave. Bensalem, PA 19020 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 8/27/99 Balto. Washingt Cro. 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility
Sterling-Ashton-Schwab Fun'l Home Inc.) ozk. Warsha Edmondson Ave. Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel acute cardiac disease or condition resulting in deeth) atherosclorote Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Physician /Medical Examiner

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/Medical

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Funeral

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Pages 1 and 2 should be nent of Health and Mental

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that initiated events resulting in death) Last	Due to (d	or as a conseguence of	41):							
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27. Menner of Death 1. Natural 5 Pending 2 Accident Investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red					
3 Sulcide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Special	ome, larm, street, lac	28l. Location (Street and Numb City or Town, State)	8l. Location (Street and Number or Rural Route Number, City or Town, State)						
				e, end due to the cause(s) and ma curred at the time, date and place,						

29c. License number

D: 4490 7 CONSUELO 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature end title of certifier

31. Date liled (Month, Day, Year)

AUG30

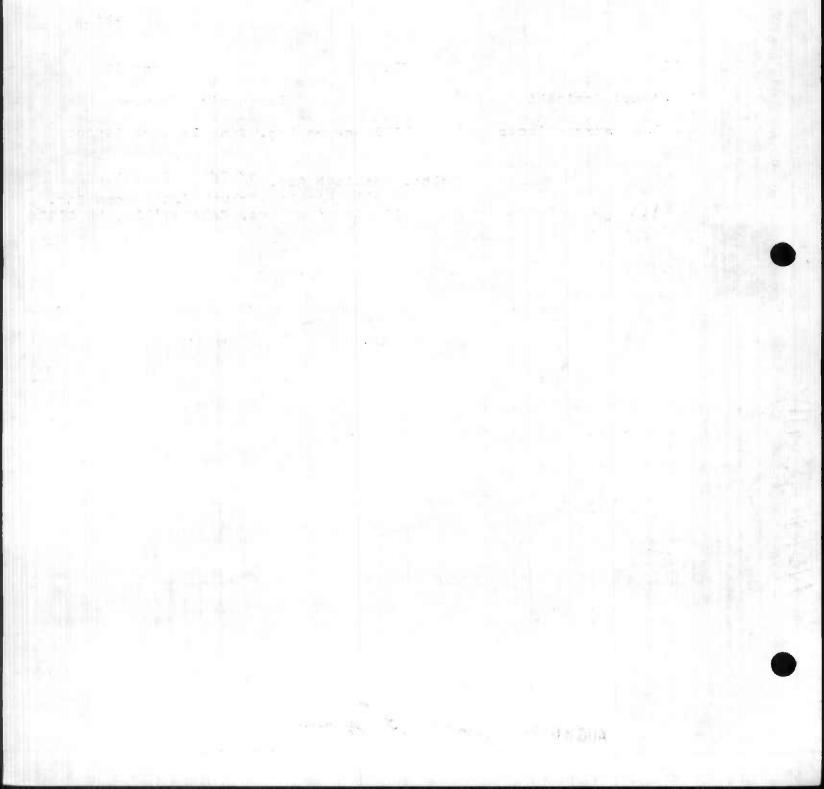
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and manner stated.

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32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month WILLIAM HENRY OTTO August 2:30 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 19,1917 9. Birthplace (State or Foreign Country) Pennsy Ivania 7. Age (In yrs. last birthday) **Funeral** Days 199-09-7819 82 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified 1 Yes XX No Maryland Baltimore Towson ij Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 800 Southerly Road Apt. 512 U.S.A. thems 23a 21286 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② Who If Yes, Give Year or Dates: 11. Marital Slatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. witc event, the Medical Examiner 1 Never Married 2 Married 8 1 ☐ Yes XXNo Specity: by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Manufacture Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **FATZINGER** HENRY HABEL OTTO SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Separtment of Health an moortant: If item 27 is r Mrs. William H. Otto Wife 800 Southerly Rd. Apt. 512 Towson, Maryland 21286 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ă Dulaney Valley Mem. Gdns. 8/28/99 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Mitchell-Wiedereld Funeral Home Inc. 6500 York Rd. Balto. Md. 21212 mah 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each eath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final A deno CAVCINOMA of unknown

Due to (or as a consequence of):

Sife weeks disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last and Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): atten signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown Yes 2 No Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 Tyes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Arp, Ce 2 1 Yes 2♥ No After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter deat To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the th 29b. Signatur and little of pertifier 29c. License number 29d, Date signed (Month, Day, Year) mo

m 23a) (Type, Print)

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Registrer's Signature

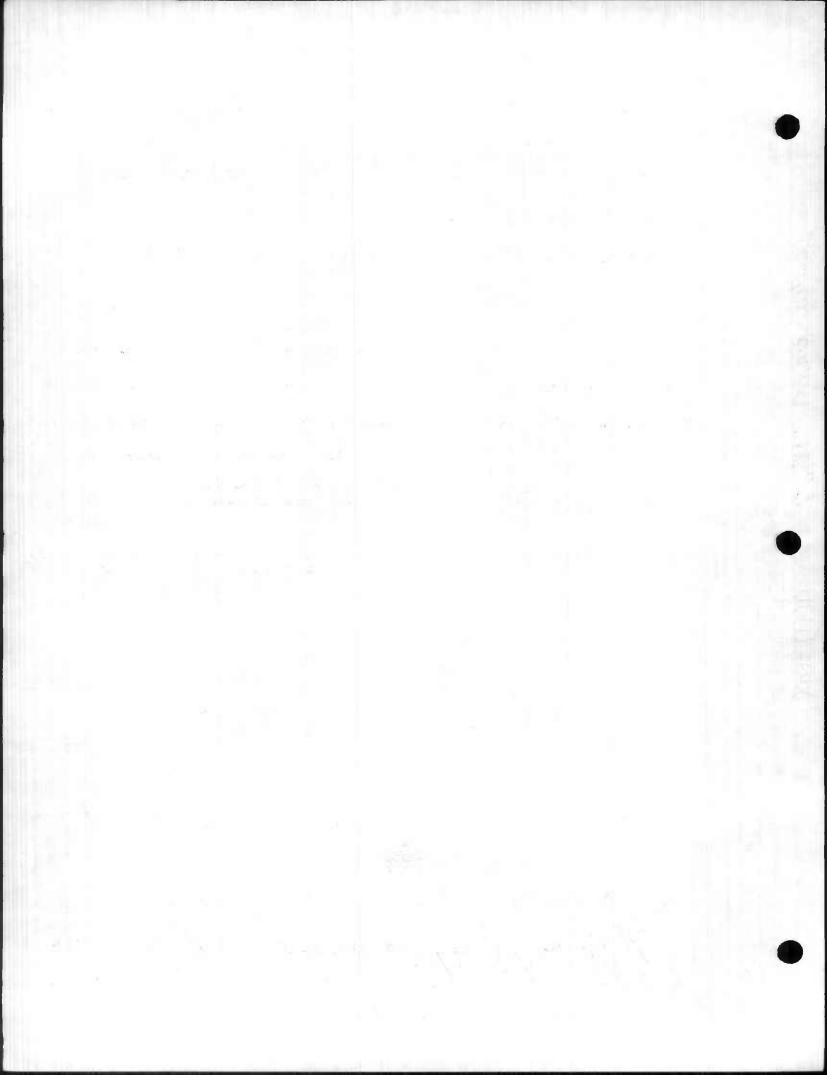
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State Registrar 30. Name and address of person who completed cause of dealers!

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31. Date filed (Month, Day, Year)

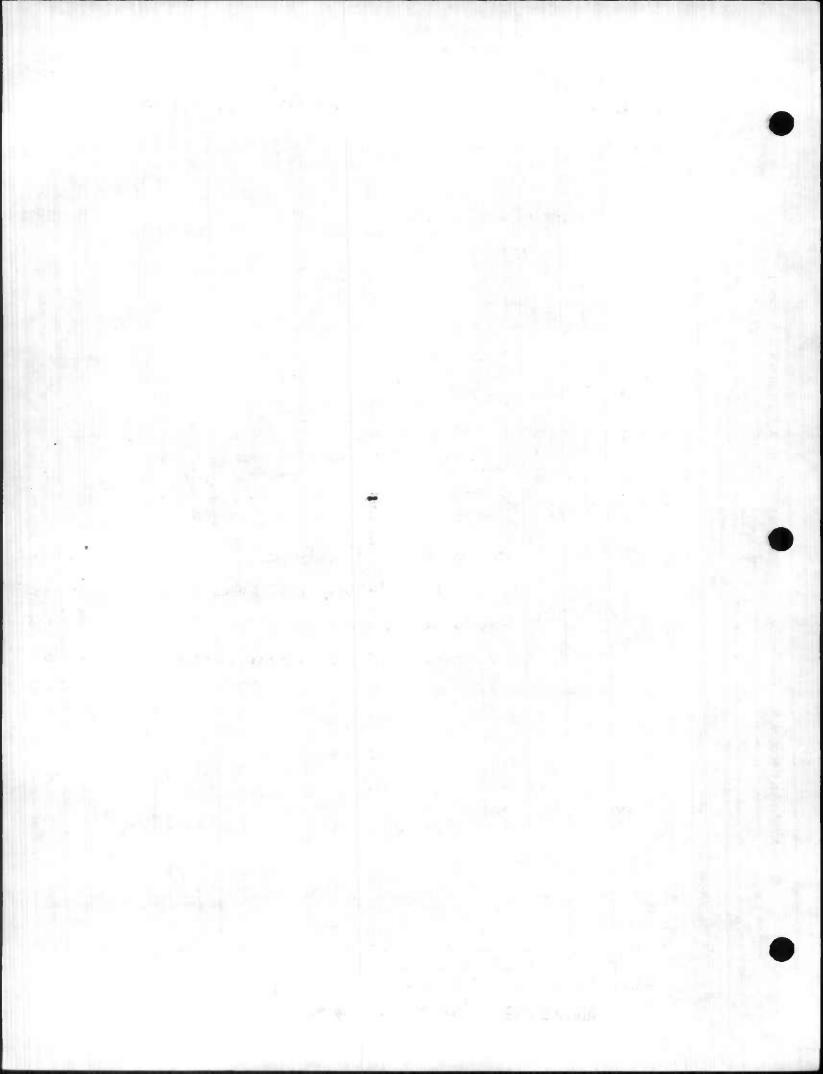


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Perlman Jacker Mar August
4b. City, Town, or Location of Death 4c 26 1999 03:30 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL 8. Data of Birth (Month, Day, Year) JAN 22, If Under 1 Yaar | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Months 1□M 2\ F Hours 212-32-0474 Yrs 65 Director 1934 MD Usuel Rasidence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits appa 1 ☐ Yas 2 No Director BALTIMORE BALTIMORE MD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 2 HARNESS COURT #103 21208 U.S.A. Barris 23a Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 1 No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc 1 ☐ Nevar Married 2 🕅 Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: WHITE Specify: ğ 3 Widowad 4 Divorced Yeer or Detas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Hygiens. other than Elamentary/Secondary (0-12) College (1-4or 5+) SECRETARY MEDICAL Pages 1 and 2 should be filed named of Health and Mental Hygid not: If Item 27 is marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) ä SAPPERSTEIN ELI COHEN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) JEFFREY BRODIE / SON 7 DEER CREEK COURT - REISTERSTOWN, MD 21136 Department of Health Important: If Item 27 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1

Burial 2 □ Cramation 3 □ Removal trom State 4 CHIZUK ZMUNO ARLINGTON 8/27/99 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE, MD 22. Neme end Address of Facility 21. Signatura of Minaral Sarvice Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Respiratory 12 hours disaase or condition rasulting in death) Examiner Examiner Brainstem physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initieted events rasulting in death) Last Dua to (or as a consequence of) Subdural Box 68760 ematora Physician/Medical Due to (or es e consequence of) oventasm YEGI avernous NUS P.O. signed by the a Part tt. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records, by 24b. Ware autopsy tindings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa ratarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Unpatiant Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending invastigation n 24 hours after death.

• Funeral Director: After the function of the functin 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Placa ot Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Hospital Medical 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. To the Hoep within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 000 MD ugust 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, Baltimore, Maryland Johns Sherwin Hooklas Hua 32. Registrars Signatura 31. Data tiled (Month, Day, Yaar) State AUG 3 0 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phillips Mogth **Physician** C0-0/1- e 11:30p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 634 Hillview Rd. Baltimore n/a If Under 1 Year If Under 24 Hrs. Hours | Min. 8. Date of Birth (Month, Day, Year)
May 19, 1920 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 1□ M 201 Yrs. 124 16 0411 79 **Director** South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 23s or 28s-f show must be notified at Maryland n/a Baltimore 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 634 Hillview Rd. 21225 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiens. Hygiens in Inspectant: If Item 27 is marked other than "natural", or item any Injury or other traumatic event. the Man 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: **Black** þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Benjamin Brown Mattie Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 Mallview Rd., Baltimore, MD Bobby E. Phillips / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 8/30/99 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, MD 22. Name and Address of Fecility CAFA Stephen D. Lohrmann P.A. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21286 Approximete Interval Between Onset and Death **Physician** Vorian Concer-STage TO /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, 1 Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was casa referred to medical 26. Placa of Deeth (Check only one) examiner 7 Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 | Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one)

State Registrar

31. Date filed (Month, Day, Year) AUG 3 0 1999

30. Name and address of person who comple

29b. Signature and title of certifier

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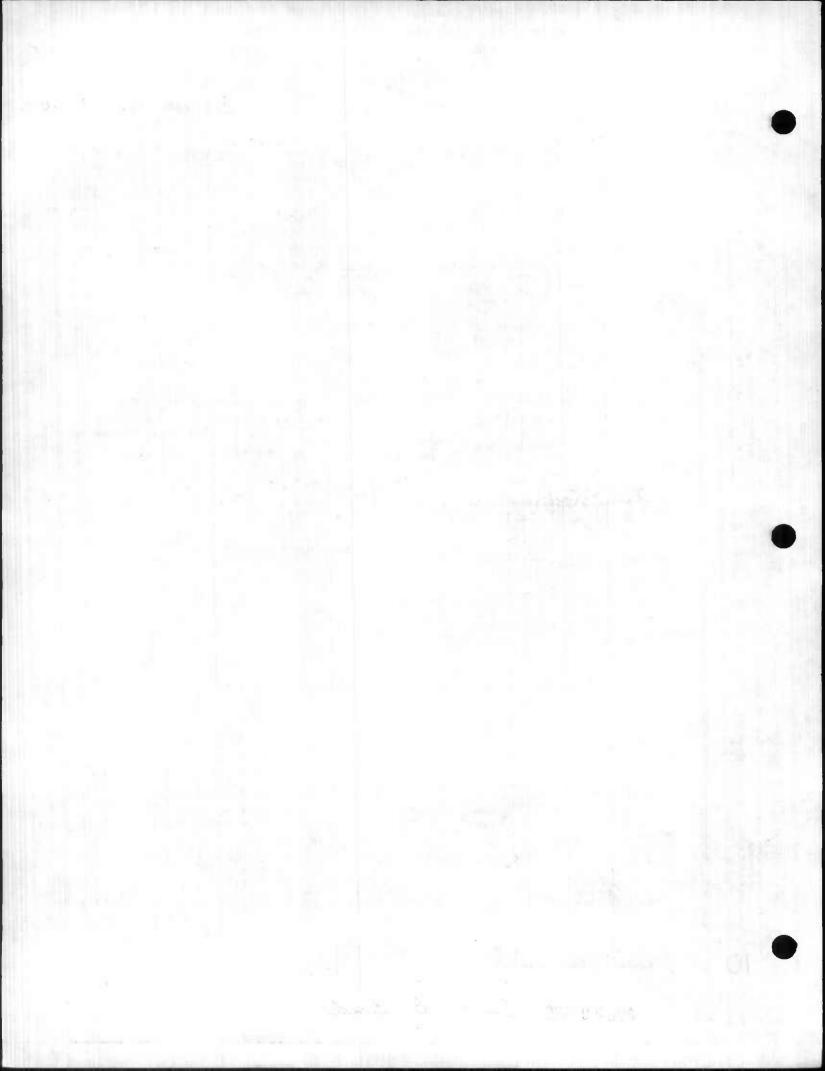
95 Aguahart Rd G.B. MD 21061 0 32 Registrar's Signature

m 23a) (Type, Print)

29c. License number

027438

29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene

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4b. City, Town, or Location of Death

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5 0 110 x 2 11 1	LEXANDRIA R	D.		CLin						
5. Social Security Number UNKNOWN	6. Sex 7. Ag	6 O	Months	1 Year If Under Days Hours						
Usual Residence of Decedent										
		7.		ARLBO						
10e. Street and Number	/ /		10f. Zip							
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1 ☐ Never Married 2 ☐ Mer	ried 1 Yes 2	No	13. Wes Deced If Yes, spec	lent of Hispanic Or ify Cuban, Mexica No Specify:						
15. Deceder (Specify only highe	16a.	Decedent's Usua (Give kind of wor	t Occupation k done during mos							
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	USUAL Residence of Decedent 10a. Stele 10b. County MD P. G 10e. Street and Number 92 14 Gobs 11. Meritel Stetus Lon Kille 1 Never Married 2 Mer 3 Widowed 4 Divorced (Specify only higher Elementery/Secondery (0-12) UNIL NO UNIL 17. Father's Name (First, Middle, UNILO 19e. Informent's Neme/Reletions P. G. Polic 20e. Method of Disposition 1 Burial 2 Cremation 4 Donetion 5 Other (S 21. Signeture of Juneret Service 123a Part 1. Enter the disease, or intock, or heart failure. List Immediate Cause (Finel disease or condition	Usual Residence of Decedent 10a. Stete 10b. County MD P, G, 10e. Street and Number 9 2 1 4 GOLDENVO 2 11. Meritel Stetus Ling Killwan 1 Never Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or SUNIL NOWN) 17. Father's Name (First, Middle, Last) UNUNOWN 19e. Informent's Neme/Reletionship (Type, Print) P.G. Declare 20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 4 Donelion 5 Other (Specify) 21. Signeture of Juneral Service Licansee 1 Part 1. Enter the disease, or complications that caused linck, or heart failure. List only one cause on each linded disease or condition	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town MD P, G, 10e. Street and Number 9 2 1 4 GODEWO LATE 11. Meritel Stetus Ling Killwon 1 Never Married 2 Merried 3 Widowed 4 Divorced Year or Detes: UNKnown 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) UNIL NOWN 17. Father's Name (First, Middle, Last) UNCNOWN 19e. Informent's Neme/Reletionship (Type, Print) P.G. Co. POLICE 20e. Method of Disposition 1 Burlat 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) ROUNT 21. Signeture of Juneret Service Licansee 1 Decedent Stetus Licansee 1 Decedent Stetus Licansee 1 Decedent Stetus Licansee 1 Decedent Stetus Licansee 1 Decedent Stetus Licansee 2 Decedent Ever In U.S. Armed Forces? 1 Yes 2 No It Ye	Usual Residence of Decedent Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location MD P, G, 10f. City, Town or Location MD P, G, 10f. Zip 10b. Street and Number 10f. Zip 11. Meritel Stetus Lan Kuraun 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Sive 1 Yes, City only highest grade completed) 15. Decedent's Education (Give kind of wor life. Do NOT us (Give kind of wor life. Do NOT us (Give kind of wor life. Do NOT us 1 Yes, City only highest grade completed) 17. Fether's Name (First, Middle, Last) UNLINOUSM 19e. Informent's Neme/Reletionship (Type, Print) P. G. D. POLICE 20e. Method of Disposition 1 Buriat 2 Cremation 3 Removel from Stete 4 Donelion 5 Other (Specify) Would 2 21. Signeture-of funcret Service Licansee D QCC TOT 22. Neme and shock, or heart failure. List only one cause on eech line.						

8. Date of Birth (Month, Day, Year) 3 - 7 - 3 Birthplace (State or Foreign Country) Days Hours UNKNOWN 10d. Inside City Limits MARLBOro 1 Yes 2 No Of. Zip Code 10g. Citizen of What Country? 20772 USA 14. Rece - American Indien, Black, White, etc. Decedent of Hispanic Origin? (Specify Yes or No., specify Cuban, Maxican, Puerto Rican, etc.) es 20 No Specify: Specify: WHITE s Usual Occupation of work done during most of working IOT use retired) 16b. Kind of Businass/Industry UNKNOWY Known 18. Mother's Name (First, Middle, Maiden Sumeme) UNICADIUM dress (Street and Number or Rural Route Number, City or Town, State, Zip Code) n (Name of ry or other place) Date 20c. Location - City or Town, State me and Address of Facility Approximete Interval Between Onset and Deeth Physician/Medical Exami Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that inhieted events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 2 No 1 Yas 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yas 2□ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death
Netural
2 Accident 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signal O.C.M.E JULY 26,1999

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funral Director: After this certificate has been signed by the attending physician and completely filled in by the funral director, page 2 should be detached for use as the businal-transit Division of Vital Records, P.O. Box 68760,

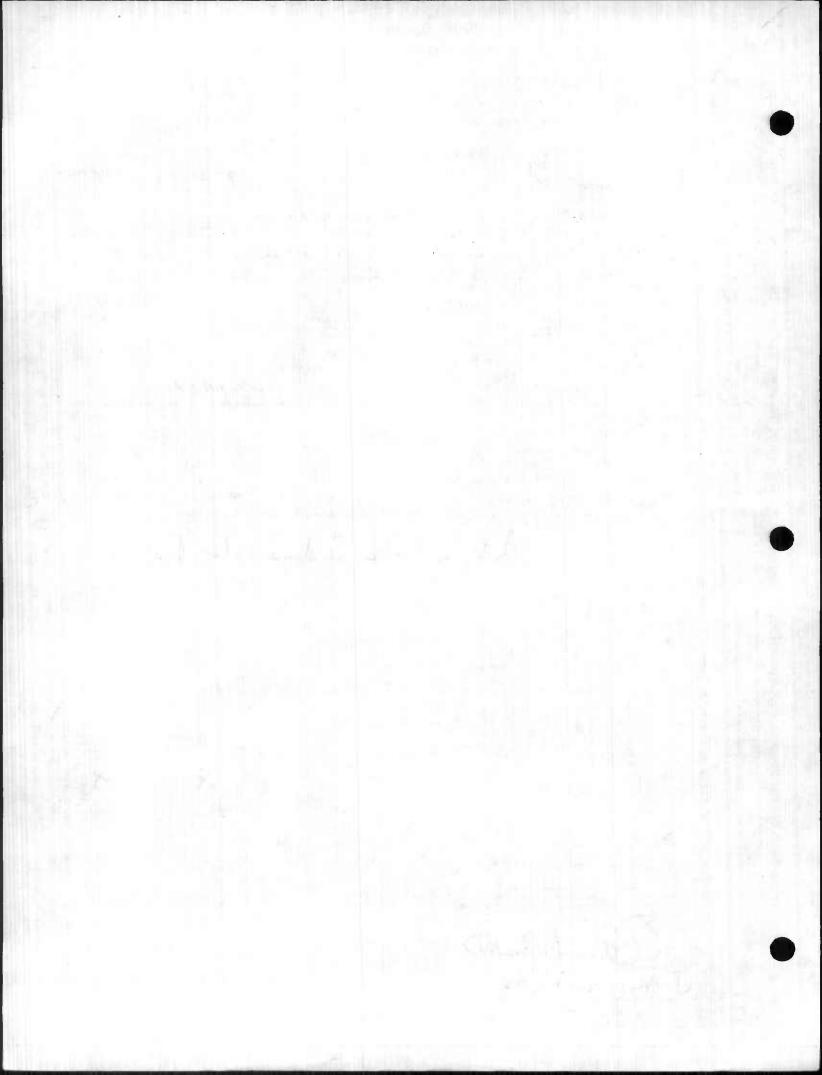
State Registrar

Medical Certification: To

OCKE

32 Registrer's Signeture

ress of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

T.FONARD

State of Maryland / Department of Health and Mental Hygiene O

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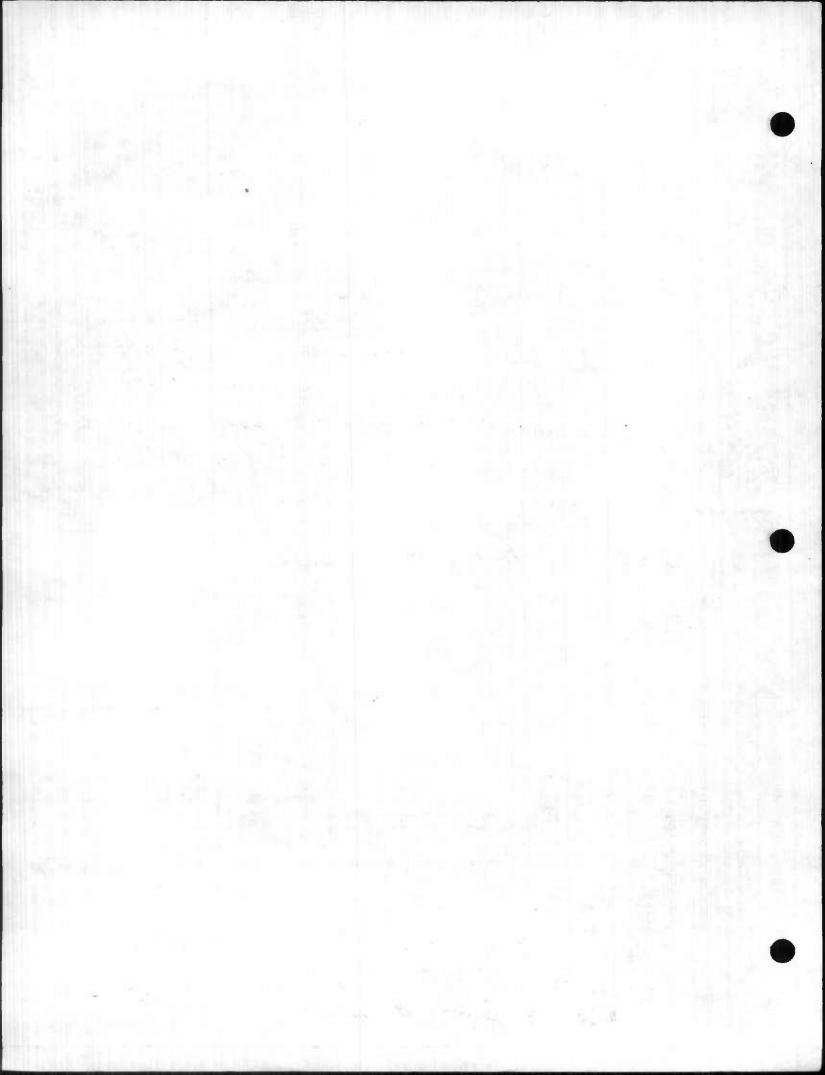
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	Physicia		1. Decedent's Neme (First, Middle, Las	Rockwel	1 0			2. Date of De Month	ath Dey	Year	3. Tima of Death		
	/Medic		LEONARD 4a Facility Name (If not institution, give		- 2		4b. City, Town, or L	AUGUST	24, 19 4c. County		7:29P.M.		
	Examin	er	1004 HILLMAN STREET				BALTIMOR		46. County	N.	A		
1-			5. Social Security Number 6. Se		et hirthday)	f Under 1 Year	If Under 24 Hrs.		th				
н	Funeral Director			ØM 2□F 2		lonths Days	Hours Min.	8. Date of Bird (Month, De	y, Year)	Coun	lace (Stete or Foreig		
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18	Atten ctor y the	E C	3 ☐ Suicide 6 ☐ Could not be	286. Piece of injury - At nor	724 p	fectory, office		28f Location /	Street and Numl	per or Puri	I Route Number,		
Division	Dire din	Certification:	4 Homicide determined	occrway near	, ,			Bo IL	en, Stete) 100	4 N.1	Hillman St.		
			29e. Certifier 1 Certifying Phy	sician: To the best of my know	ledge, deeth oo	curred et the tir	ne, date and place,	and due to the	cause(s) and me	enner as s	tated.		
	Fun Fun	edical	(Check only a Medical Exami	iner: On the basis of examinetic and manner stated.	on and/or inves	tigation, in my o	pinion, deeth occur	rred at the time,	date and place,	and dua to	the cause(s)		
	Withir To th	¥	29b. Signature and title of certifier	04		29c. Licens	e number		29d. Dete signe	d (Month,	Day, Year)		
			1 Semme	Churtzn		O.C.	M.E.		AUGUST :	25.19	99		

State Registrar

31. Date filed (Month, Day, Year)
AUG 3 0 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral Director

the Maryland must be notified at death Herna: pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examinations.

Baitimore, Maryland 21215-0020

Physician /Medical Examiner

sician end burial-transit physician s the burial Box 68760. the death certificate be USB ed by the a P.O. Records, Sign The law page 2 s has of Vitai Physician: this funeral Affer Division Attending death. after death Director: n 24 hours after dea Ne Funeral Director pletely filled in by th ò Hospital

TERRY LYNN ROTHHOLZ Certificate of Death 1. Decedeni's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day TERRY ROTHHOLZ 24, 1999 2047 PM AUG, 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 207 APT-T-3 DUKE OF YORK LANE COCKEYSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) Days Months 1 M 2 1 F Hours 215-42-9095 56 Yrs APR. 3,1943 MD Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 Yes 2 No MD BALTIMORE Director COCKEYSVILLE 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code 207 APT. T-3 DUKE OF YORK LANE 21030 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: WHITE Specify: Àq 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) 8 SAM SLON FRIEDA BARR 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GARY ROTHHOLZ / STEPSON 1150A WEST OLD LIBERTY ROAD- SYKESVILLE, MD 21784 20e. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEMETERY 8/27/99 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Intra-Oral Gunshot Ubund Immediate Causa (Final disease or condition rasulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 Pres 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SXRasidenca 6 Other (Specify) 2 XX Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Mannar of Death Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 PNo self-inflicted gumbor wand invastigation 8-24-99 2 Accident 2045 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Suicide 4 ☐ Homicide edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E AUG. 25, 1999 mash um 30. Name and addrass of person who impleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ennited Chuters

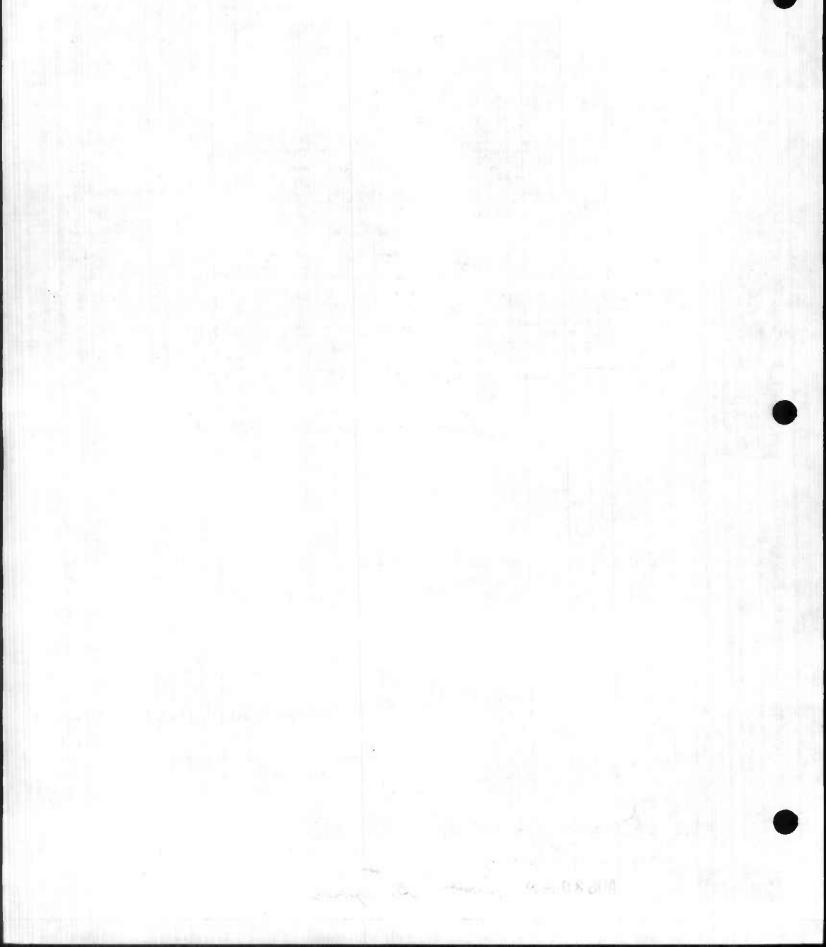
State Registrar

31. Date filed (Month, Day, Year)

AUG 30

DHMH 16 Ray 6/95

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 10:35 Am Romberger Angusi /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deetl Examiner Burnie slen unde HOSPITA runde. If Under 24 Hrs. 8. Date of Birth (Month, Dey, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 220-18-406 10 M 32F Months Days MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, tra Wad cal Examiner must be notified at Ms 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? LIDGE 21061 USA Glen Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2/10 No If Yes, Giver Yeer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 200No Specify: þ Specify: WHITE 4 Divorced 3 Widowed Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Hygiene. TECHNICIAN EDERAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental DOROthy Bruce 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) NANCY REDELIUS HOPKINS ST. GLEN BURNIE, MD 21061 27 If Item 2 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any Injury o 4 Donation 5 ☐ Other (Specify) 21. Signature of Funarel Service Licensee 22. Name end Address of Facility acel Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consequence of) Due to (or as a consequence of) been signed by the etter should be detached for Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA Innation this 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Naturai 5 Pending 1 Yes 2 No Investigation 2 Accident

Rom BERGER

ANN

Baltimore,

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: efter death. completely filled in by within 24 hours e To the Funeral D To the

Registrar

edical

29c. License number 29b. Signature and title of cartifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

🔟 Certifying Physician: To the best of my knowledge, daath occurred et the time, dete and placa, and due to the causa(s) end menner as stated.

30. Name and addless of person who completed cause of death (Ijem 23a) (Type, Print) 301 Ver aug!

6 Could not be determined

32. Registrar's Sig

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

3 Suicide

29a. Certifier

4 Homicida

(Check only one)

31. Date filed (Month, Day, Year)

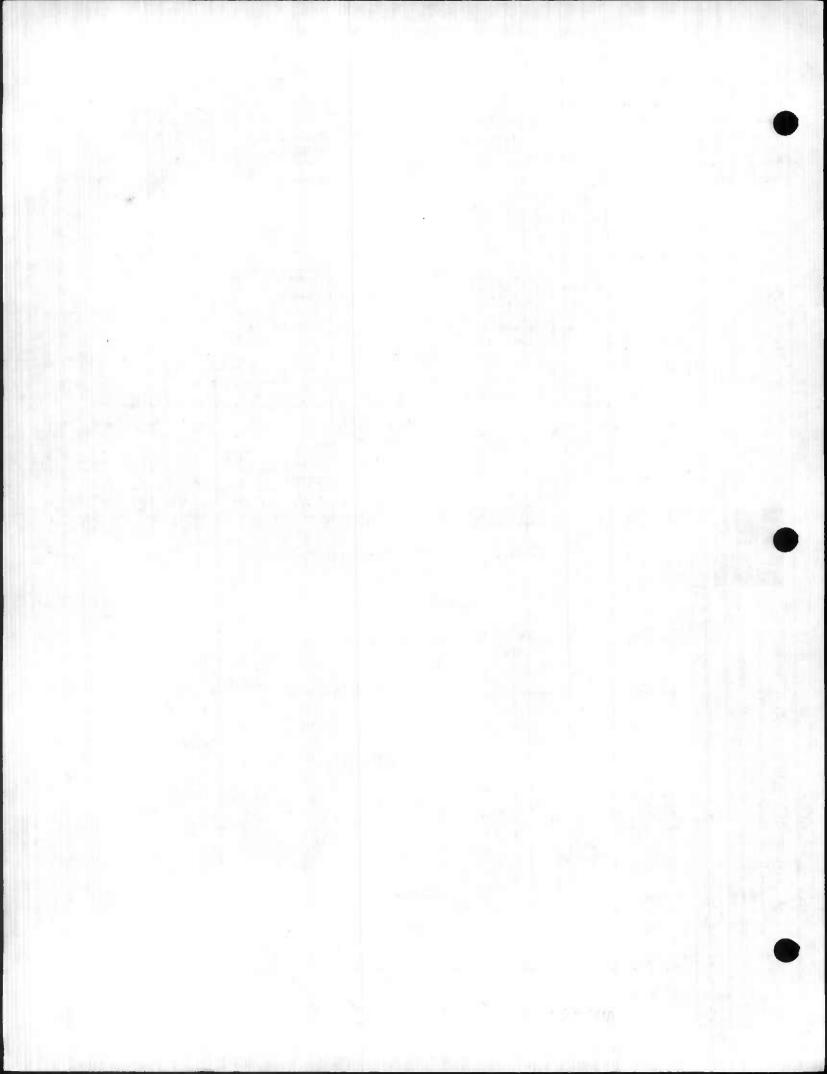
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					State	oi iviai yi			tificate of	Death	wentai my	Reg. No.	99	27126
	Physicia /Modic	_	1. Decedent's Name (First Doris E. Sa	SALVE SERVICE SERVICES							2. Date of Do Month Augus	eath Day	Year .999	3. Time of Death 7:30 P.M.
	/Medica Examine	_	4a Fecility Name (If not in						- 1	4b. City, Town, or L		h 4c. Cour	nty of Death	
			Genesis Eld						If Under 1 Year	Brooklyn If Under 24 Hrs.			Arun	
	Funeral Director		5. Social Security Numbe 212–18–7992 Usual Residence of Dece	1	ex □M 223F	7. Age (In) 78		Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D	6, 1920		place (State or Foreign http) yland
	pue Me ma	1		County		10c.	City, Tow	n or Loc	ation				1	IOd. Inside City Limits
	ith with the Maryler 23e or 28e-f show ust be notified at	è	Maryland Anne Arundel Linthicum											1 ☐ Yes 2/2 No
	or 28	Š	Maryland Anne Arundel Linthicum 100. Street and Number 101. Zip Code									10g. Citizen o		
	23e		414 Clevela	and Rd.					21090			United		
Maryland 21215-0020		by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 0		Armed F	2⊠No live	n U,S.	If	/as Decedent of P Yes, specify Cub ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	В	ace - Americ lack, White, ^{city:} Whit	etc.
2-0	n 72 hours	8	15. E	ucation		16a.	16a. Decedent's Usual Occ		Occupation		16b. Kind of	Business/In	dustry	
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ore	of 19 and		20a. Method of Dispositio	n			b. Place of	Dispos y, crem	ition (Name of atory or other pla	ce)	Date Aug. 30	20c. Locatio	n - City or To	own, Stete
Ĕ	artmant of sortant: If Its Injury or of		4 Donation 5 0		on 3 □Removel from State (Specify) Me			etro Crematory, Inc.					Catonsville, Maryl	
Baltimore,	Departi Departi Import any in		21. Signature of Funeral	Service Licen	الد			Ki		ess of Facility addick Fu Hwy., S.				21061
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о. О	that the ded by the deteched	E L	Part II. Other significant (conditions co	ontributing to d	seath but not	resulting in	the un	denying cause gr	ven in Part I.		Yes 2□ No		the cause of death? bebly 4 Unknown
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m m	The law	E									10	Yes 21 No	1[Yes 2□ No
/ita	ysician: The l s certificate he director, page		25. Was case referred to examiner?	+						26. Place of Dea	th (Check only	one)		
5		2	1 ☐ Yes 2 ☒ No				2□ ER/Ou		3LI DON		ome 5 Res			(v)
	After this funeral di			Pending investigation		of Injury oth, Day Yea		ime of njury	28c. Inju Wo	ryat rk? Yes 2 □ No	28d. Describe	how injury occ	Derrur	
Division	or Attending after death. Director: After In by the fune	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Plac	e of Injury - A ling, etc. (Sp	N home, fe	rm, stre	et, fectory, office			(Street and Numer, State)	mber or Fluri	al Route Number,
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	To the within To the comple		29b. Signature and title of	certifier	GENT THE	otelou.			29c. Licens	se number	I	29d. Dete sig	ned (Month,	Day, Year)
	- s - ö		18m	sul	Du	~			DY	0491		Augus	t 30,	1999
		-	30. Nama and address of	person who o	completed cau	se of death (Item 23a) (Type, F	Print)		0 1			
	11-11-11-1		YED M.	A. R	142	200	VOVEC	- H	aumon	& sury	Kol (1h/hic	-NM	21010
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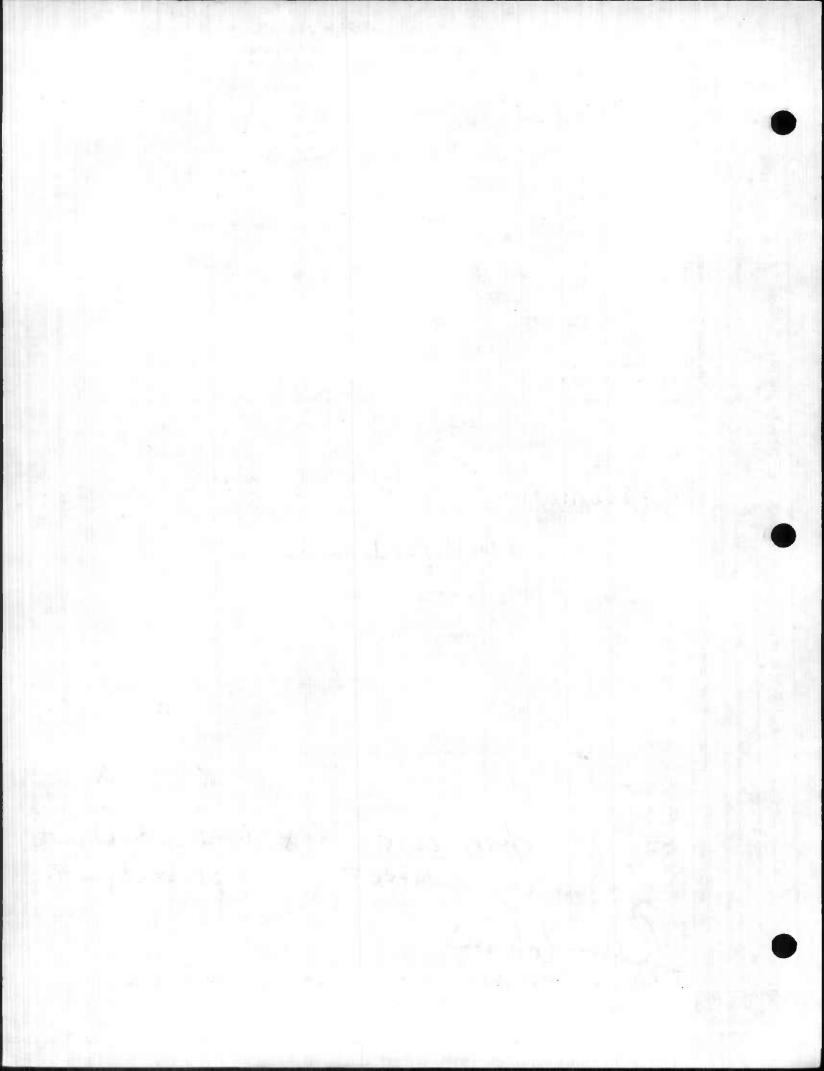
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		JIAM SICKLE 1. Decedent's Nama (First, Mic		of Mary		tificate of		2. Data of D		99	27/27 3. Time of Death
Physi /Med		Scott Wi	lliam Sic	kle				AUG.	26, 199	Yaar 99	2310 PM
Exam	iner	4a Facility Nama (If not institut 700 BLOCK WES			NUE		4b. City, Town, or BALTIMO		th 4c. Count	y of Death	
Funera Directo		5. Social Security Number 216-04-7334 Usual Residence of Decedent	6. Sex 1 2 M 2 □ F		yrs. last birthday) 15 Yrs.	If Undar 1 Yaa Months Days		(Month, L	irth Day, Year) 1, 1983	Cou	place (Stata or Foreig ntry) y land
yland		10a. Stata 10b. Coun	ty	100	c. City, Town or Lo	cation					10d. Inside City Limits
n the Maryland r 28a-f show	Director		ltimore		Baltimon						1 ☐ Yas 2 ☒ No
with th		10e. Street and Number				10f. Zip Code			10g. Citizen of		
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72 hours after death with the Manyland natural', or items 23a or 28a-f show dies Examine must be notified at	by	1 Nevar Married 2 Mi 3 Widowed 4 Divorce	Armed 1 Yas	Forcas? s 2⊠No		Yas, specify Cul	Hispanic Origin? (S ban, Maxican, Puart Specify:	o Rican, atc.)		ck, Whita, ^{'y:} Whit	atc.
vithin hen.	Completed	15. Deced (Specify only high Elamentary/Secondary (0-12	ant's Education past grada complate Coilege	od) a (1-4or 5+)	(Giva lifa. L	lant's Usual Occu kind of work done OO NOT use retin	upation a during most of wor ed)	king	16b. Kind of B		
should be filed vand Mental Hygie	To Be C	17. Fathar's Nama (First, Middl Richard Wayne						na (First, Middl la Jean	a, Maiden Sumai Heard	ma)	
d 2 should th and Mer 7 la marke traumatic	-	19a. Informant's Name/Ralatio	nship (Type, Print)		19b. Mailin	g Addrass (Stree	et and Number or Ru	ıral Routa Num	ber, City or Town	, Stata, Zi	o Code)
is 1 en if Heal item 2 other		Richard Wayne 20a. Mathod of Disposition 1 ⊠ Burlal 2 □ Cramation 4 □ Donation 5 □ Other	n 3 □Ramoval fro	m State	Ob. Place of Dispo	sition (Nama of natory or other pla	ace)	Baltimo: Data 8/31/99	20c. Location	· City or T	
pemit. Page Department of Important: If any Injury or		21. Signature of Funaral Service 23a. Part 1. Enter the disease,	Myse	Lau	yle	2719 Ham	Funeral H monds Fer	ry Road	Lansdov		MD 21227
Physician /Medica Examine	l r	shock, or haert tailura. Li Immediata Causa (Final disaasa or condition rasulting in death)	a	Mu L	to (or is a conseq	Diju	ries			1	Intarval Batween Onset and Death
seth certificate be executed attending physician and for use as the bunal-transit	Physician/Medical Examiner	Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Last	b c		to (or as a consequence to (or as a consequence)					1	
that the deeth cer ed by the attendin detached for use	ysiciar	Part II. Other algnificant condi	tions contributing to	deeth but no	t rasulting in tha ur	ndarlying causa g	iven in Part I.	23b. Die	d tobacco una co	ontributa 1	o the cause of death
s that the ined by a detact	by Ph							10	Yes ZNNo	3 Pro	bably 4 Unknow
he lew requires that e has been signed I age 2 should be det	Completed b							24a. Wa	s an autopsy formed?	a C	Vara autopsy findings vailable prior to omplation of causa death?
	Con							A	Yas 2 No	1	Yas 2 No
Physician: The I this certificate ha	B	25. Was casa rafarred to medic axaminar?	Hospifal:			10	26. Place of Dea	ath (Check only	ona)		
ding Physia. After this of	tlon: To	27. Manner of Death 1 Natural 5 Penc	28a. Da	Inpatiant ta of Injury onth, Pay Yea	2 ER/Outpatien 28b. Tima of Injury	28c. Inju		loma 5 Ra	sidanca 6/20th	rred	MAT SCENE
To the Hospital or Attending Physician: Twithin 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p.	Certification:	3 ☐ Suicida 6 ☐ Coul	d not be 28 . Pla	ica of Injury -	At homa, farm, stropecify)			28f. Location City of T	(Street and Num	per or Run	at Routa Number,
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Certify (Checkmon XXX) Medica	ing Physician: To the Examiner: On the	ha best of my basis of axar annar statad.	knowledga, daath mination and/or inv	occurred at tha trastigation, in my	tima, data and place opinion, daath occu	, and dua to the	a cause(s) and m	annar and dua	to the cause(s)
To the within To the comple	M	29b. Signature and title of certif	- /	w)		O.C.M.E		29d. Data signed AUG.		
		30. Name and address of person	n who complated ca	usa of death	111 Pen	Print)	, Baltimo	ore, Mai	+ 7		

State Registrar

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** DM /Medical 4b. City, Town, or Location of Death 4c. County of Death lity Name (If not institution, give street and number) Examiner AHIMOR 8. Date of Birth (Month Day, If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 10 M 2□ F 240-68-4 722 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location t 0d. Inside City Limits must be notified at 1 Yes 2 No Director MOLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21200 50 permit, Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or florm 29a and injury or other traumatic avent, the Medical Experiment 284 and follows. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐dNo Specify: þ ACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MASTERS hine 01 era A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 W. 2 Ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 HAR 10 wan a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maun 1 (em 22. Name and Address of Facility 3e #5 21. Signature of Funeral Service License 5+ Aroline e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Mama physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): mia Physician/Medical Due to (or as a consequence of): 680 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificata or Attending Physician: director. 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation Director: After 1. Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the function. 1 Yes 2 No 2 Accident Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year) AUG 3 0 1999

A

29b. Signature and title of certifier

(Check only one)

SHOAIIS

HAPItm1 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Entow St Suite 308 MD 821

MD

ORIGINAL

29d. Date signed (Month, Day, Year)

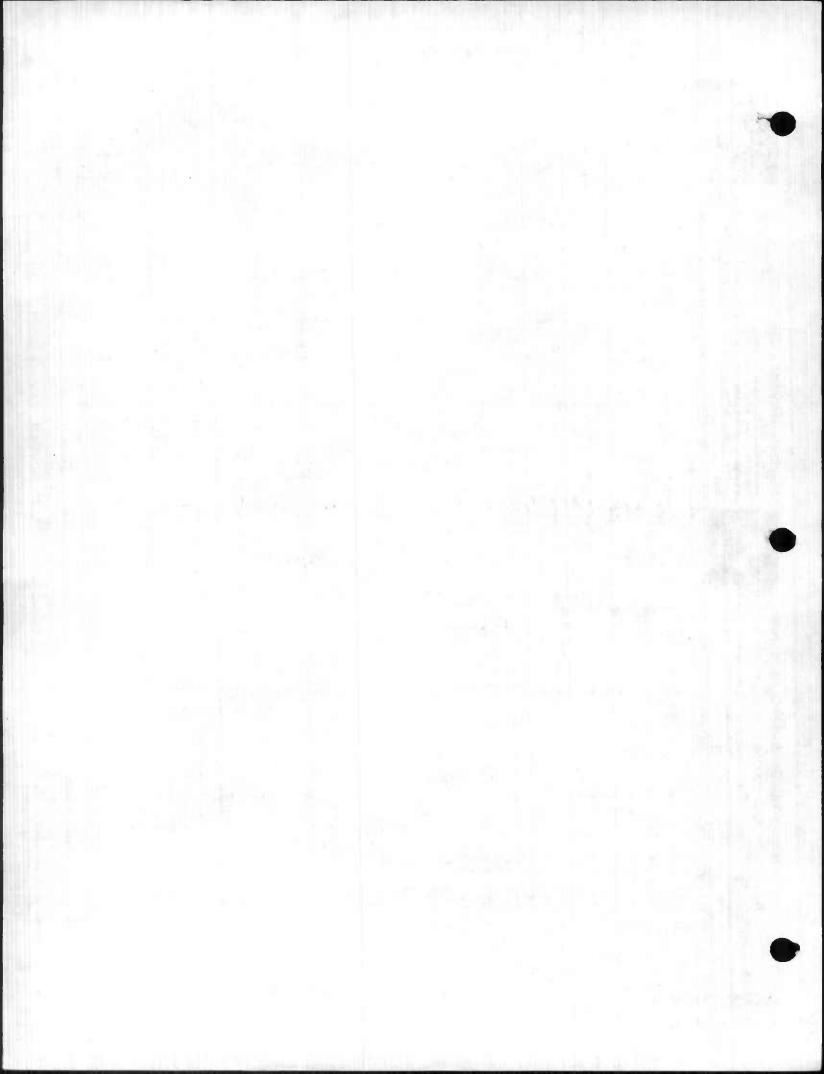
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Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital



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I	KLAUS SCHUTZ AM	MEN	D ITEMS: #23 PART i, 27	State of Maryla PER MEO G775 9-				d Mental Hy	/giene	9 27	129
			1. Decedent's Neme (First, Middle, Las	t)	_			2. Date of D	eath		ima of Death
	Physicia /Medic		KLAUS PE	TER SCHUT	Z			AUGUST	25,19	Year 11:	.M.A00
	Examin	_	4a Facility Name (If not institution, give					or Location of Dee			
			FRANKLIN SQUARE H				ESSE			IMORE	
	Funeral Director		5. Social Security Number 215-523014 Usual Residence of Decedent	9X 7. Age (fn yrs	45 Yrs.	Montha Da		lin. (Month, D	irth lay, <i>Year)</i> t 19,195	9. Birthplace (S Country) 4 Germa	
	Mend	Ì	10a. State 10b. County		ity, Town or Lo					10d. Ins	side City Limits
	er death with the Manyler Nema 23a or 28e-f ahow ner maint be notified at	ctor	Maryland Baltimo	re	Pery I	Hall				10	Yes 2⊠No
	章 9 g	Dire	10e. Street and Number			10f. Zip Cod			10g. Citizen of		
	23°	ara!	9213 Greenhouse		10 1.0		236		U.S.A		
020	a 8	by Funeral Director	11. Meritel Stetus 1 ☑ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in the Armed Forces? 1 ☐ Yas 2 ☐ Mo If Yes, Give Yaar or Datas:		Wes Decedent of Yes, apecify C		(Specify Yas or Nuerto Rican, etc.)	Specify	ck, White, atc. White	18n,
21215-0020	natural',	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Oc	cupation ne during most of	working	16b. Kind of B	usiness/Industry	7- 3
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Maryiand	2 5 5 5	o Be	Frederick	Schut	.7				Nowak	ria)	
ary	# DEE	F	19a. Informant's Neme/Reletionship (T			ng Address (Str	•	Rural Routa Numi		State, Zip Code))
	D = C =		Sophie B. Fernande	z - Mother	Same	e as #10)				
Baitimore,	8077		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I		Plece of Dispo cemetery, crea	osition (Name of matory or other	place)	Dete	20c. Location	City or Town, St	ete
##			4 ☐ Donation 5 ☐ Other (Specify,	G		of Fait		30/99	Baltim	ore, MD	
Bai	permit. Pag Department Important: I any Injury o		21. Signeture of Funeral Service License	usonedz		2. Nama end Ad Leonard	J. Ruck,		re,MD 2 305 Harf		
	Physician /Medical Examiner	iner	shock, or heart feilure. List only of Immediate Cause (Final disease or condition resulting in death)	ARTERIOSCLE	ROTIC CAR (or as a consec		LAR DISEASE				el Between t and Death
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Records	law requires as been sign 2 should be	Completed b						24a. We per	s an autopsy ormed?	24b. Were aut available completic of death?	prior to on of cause
	The law ate has page 2	E						10	Yes 2□No	1 ☐ Yes	2 No
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Division	after death. Director: After	Certification:	2 Accident 3 Sulcide 4 Homloide	28e. Place of Injury - At I				28f. Location	(Street and Numi	ber or Rural Route	e Number,
Ö	as after in the interest of th	Sel	Tomode	building, etc. (Spec	119)			City of 70	iwii, State/		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edica		elclan: To the best of my kn ner: On the basis of examin- and menner steted.							ause(s)
	To to t	Σ	29b. Signatura and titia of certifier	0.01		29c. Lic	ense number			d (Month, Day, Y	(ear)
			Michinto	rellale			O.C.M.E.		AUGUST	26,1999	
	^	-	The state of the s								
	State		30. Name and eddress of person who or AND MARCON DO 31. Date filed (Month, Day, Year)	ompleted cause of death (Ite LORGW 32. Registrar's Sign	m.		n Street	, Baltim	ore, Mar	yland 21	1201

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State of Maryland / Department of Health and Mental Hygiene

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	Cert	ificate	of	Death		

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August 20, 1999

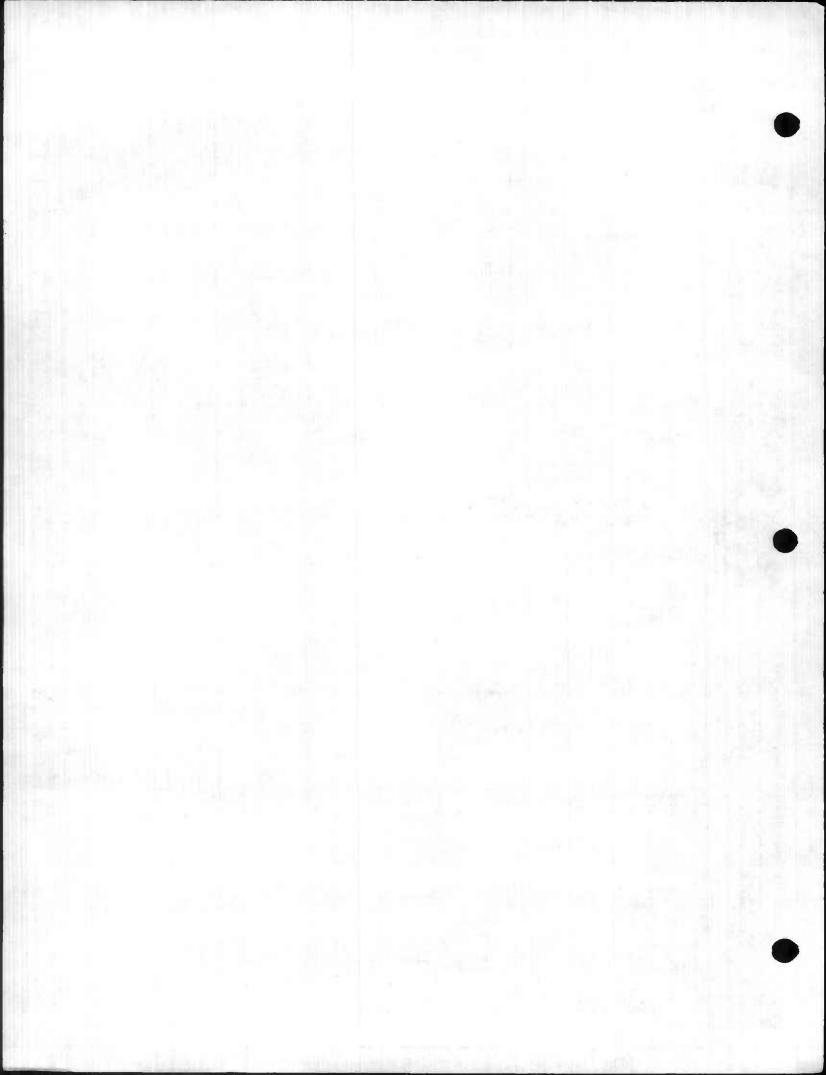
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		913 Holgate	Drive Apar	tment L		Ess	ex	Ba	ltimo	re
	Funeral Director	5. Social Security Number 6. S 262-55-3209	Sex 7. Age (1 M 2 F 27	in yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Dey, 09-27-	Year) .71	9. Birthple Count MD	ace (State or Foreign ry)
	P .	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	postino				100	d Applied City I (min-
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	vith the Mar t or 28a-f e be notified Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Count	ry?
	ath w	913 Holgate D			2123			USA		
21215-0020	urs at	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yas 3 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yas, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, atc.)	Bla	ce America ck, Whita, a by: Bla	tc.
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Maryland	d 2 sho h and 7 la m traum	19a. tnformant's Name/Relationship (Deirtra Pitt	Type, Print)	19b. Maili		and Number or Rui Oak Driv				
ē,	- F E E	20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other pla	ina)	Date 2	Oc. Location	- City or Tov	m, Stata
E		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif				k. Cem.	08-27-9	9 Ra	andal	lstown, MD
Baltimore,	permit. Peg Department Important: t eny injury o	21. Signature of Funaral Service Licer	nsee	22	2. Name and Addre	en at English	ltimore	, Mar		d 21202
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of V	2 00 7	1X Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	1 3 DOA OH	her: 4 Nursing Ho	ome 5 X Resider	ice 6 Ott	ner (Specify)
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Division	오류는 다	3 Suicida 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, tarm, str Specify)	eet, tactory, office		28f. Location (Str. City or Town,	eet and Num. Stete)	ber or Rural	Route Number,
	Hospi 4 hou Funer tely fill		yaician: To the best of miner: On the basis of example and manner stated	amination and/or in						
	within 2 To the comple	29b. Signature and title of certifier	,	110	29c. Licens	se number	29	d. Date signe	od (Month, E	Pay, Year)

State Registrar

Pestag 111 Penn Street, Baltimore, Maryland 21201 42 Registrar's Signatury

dress of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND #12 PER A.B. G774 8-30-99 J.A. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev 10:50 AM WALTERB. SHAW AUGUST 23 1999 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE H Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) 3 - 2 5 - 2 1 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 12M 2DF 217-09.0377 no Yrs. Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BACTIMORE Owings Mills 1 Yes 2 No MD 10f. Zip Code 10g. Citizen of Whet Country? 9927 USA Wes Decedent Ever in U.S. Armed Forces? 12 Yes 2 10 No If Yes, Give Yeer or Detes: 42 - 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bteck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) SPOTTS EQUIPMENT SAW OPERATOR 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) WALTER SHACO MROLINE Brook 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dorother ShAW WIFE 20s. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility 23a Hartt Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, hock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) EARS · CONGESTIVE Due to (or es e consequence of) Due to (or es e consequenca of): Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1/2 Yee 2 No 3 Probably 4 Unknown ARTERY DISEASE 24b. Were autopsy findings avelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? EMPHY SEMIA 25. Wes case referred to medicat exeminer? Hospital 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitet: 1 █ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Naturel 1 Yes 2 No Investigation 2 Accident 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Physician/Medicai

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

r is marked other than "natural", or items 23a or 28a-f show treumstic event, the Mooi cal Examinal must be notified at

. or h

filed within 72 hours effer Hygiene.

should be fand Mental 8

permit, Pages 1 and 2 sh Department of Health end Important: If Nem 27 Is m

Physician /Medical

Examiner

physician

signed by

certificate hes

After this

death.

e Hospital or Attendi n 24 hours efter death, te Funeral Director: A

within 24 hor To the Fune completely fi

funeral director,

filled in by

þ

Completed

Be

Certification: To

certificate be executed

Division of Vital Records,

Attending Physician:

Baltimore,

end l

ATRIAL FIBRILLATION

1 Yes 2 No

27. Manner of Deeth

3 Sulcide 4 Homleide

(Check only one)

29a. Certifier

6 Could not be determined

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end pteca, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

K.S.RAO.TI.D

0 43462

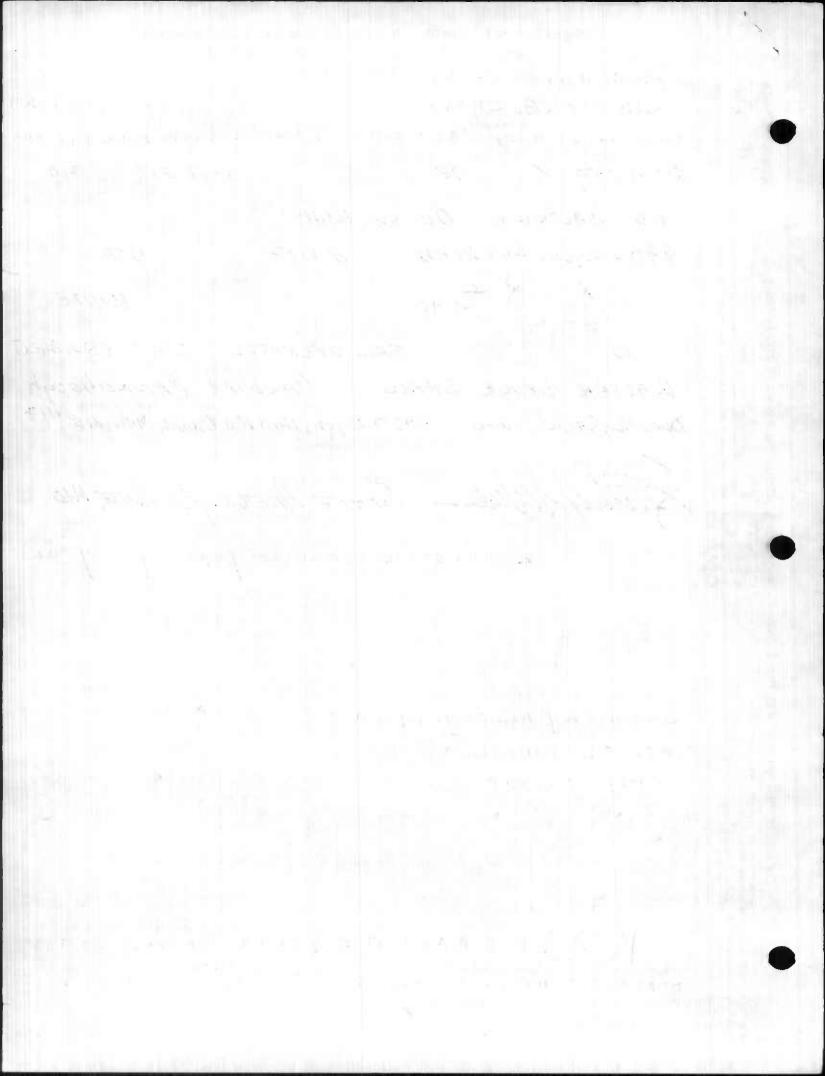
AUGUST 23,1999

30. Name and address of person who completed cause of death (ttern 23e) (Type, Print) 1 . S. R. A.O. M. D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN.

Registrar

31. Dete filed (Month, Dey, Year) AUG 3 0 1999

32. Registrer's Signeture Sports



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death STARK Oldenburg ouise 6:40AK 4e. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deeth 4c. County of Deeth Rockville Mon If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Country) 577-24-9735 10 M 20 F Decedent Usuel Residence of 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20850 USA DRIVE 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Reca - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No 3 Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNIVERSIT LIBRARIAN 10 17. Fether's Neme (First, Middle, Last) Olden SURG DRAKE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) 30815 19e. Informent's Name/Relationship (Type, Print) TACQUEINE 5502 Grove CHEUY CHASE, BAUGISTER 20b. Ptece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete

Physician /Medical Examiner

permit. Peges 1 end 2 should be filed within 72 hours efter death with 1 Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "naturel; or items 23a or any injury or other traumatic event, the Medical Examiner mans be no

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a Stete

MID

Completed by Funeral Director

Be

Funeral

Director

the Maryland to or 28a-f show

Physician/Medical

21. Signature of Funerel Service		22. Name end Address of Fecility STATE ANATONU	Ba BAT	Mis
23a. Pert1. Enter the disease, shock, or heert failure. L	of complications that caused the deeth. Do st only one cause on each line.	o not enter the mode of dying, such as cardiac of		Approximete Intervel Between Onset end Deeth
Todaking in deetily	b. Were to (or exe	e consequence of): / ee clip	٠	10wks
Sequentielly list conditions, if ony, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest	. atria	consequence of):		years
Part II. Other significant condi	d. Sions contributing to death but not resulting of Aneur	in the underlying cause gives in Part I. PART - Sup Si S	23b. Did tobacco use contribu	ute to the cause of death?

or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, is cermicate has been signed by the director, pege 2 should be detached Be Completed by After this certificate has 25. Wes case referred to medical exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 1 Yes 2 No filled in by the funeral 27. Mannes of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation 142/Natural death. To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

26. Place of Death (Check only one)

24e. Wes en eutopsy performed?

1 🗆 Yes

2 No

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

3 🗆 (AOC	Other: 4	Nursing H	lome	5 Residence	8 □Other (Specify)
М	28c.	Injury et Work? 1 🗌 Yes		28d.	Describe how inj	ury occurred

 Pleca of Injury - At home, ferm, street, fectory, offica	28f. Location (Street end Number or Rural Route Number,
building, etc. (Specify)	City or Town, Stete)
lan: To the best of my knowledge, deeth occurred et the time, dete er r: On the basis of examination end/or investigation, in my opinton, dee	nd plece, and due to the ceuse(s) end menner es stated. eth occurred et the time, date and pieca, and due to the cause(s)

one)	end menner steted.	agonor, army openor, occur occurred	of the time, date and pieca, and due to the cause
29b. Signature end title of certifier	J. Carother	29c. License number 0 2 1 7 2 6	29d. Dete stgned (Month, Day, Year)

30. Neme and eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

Certifying Physic

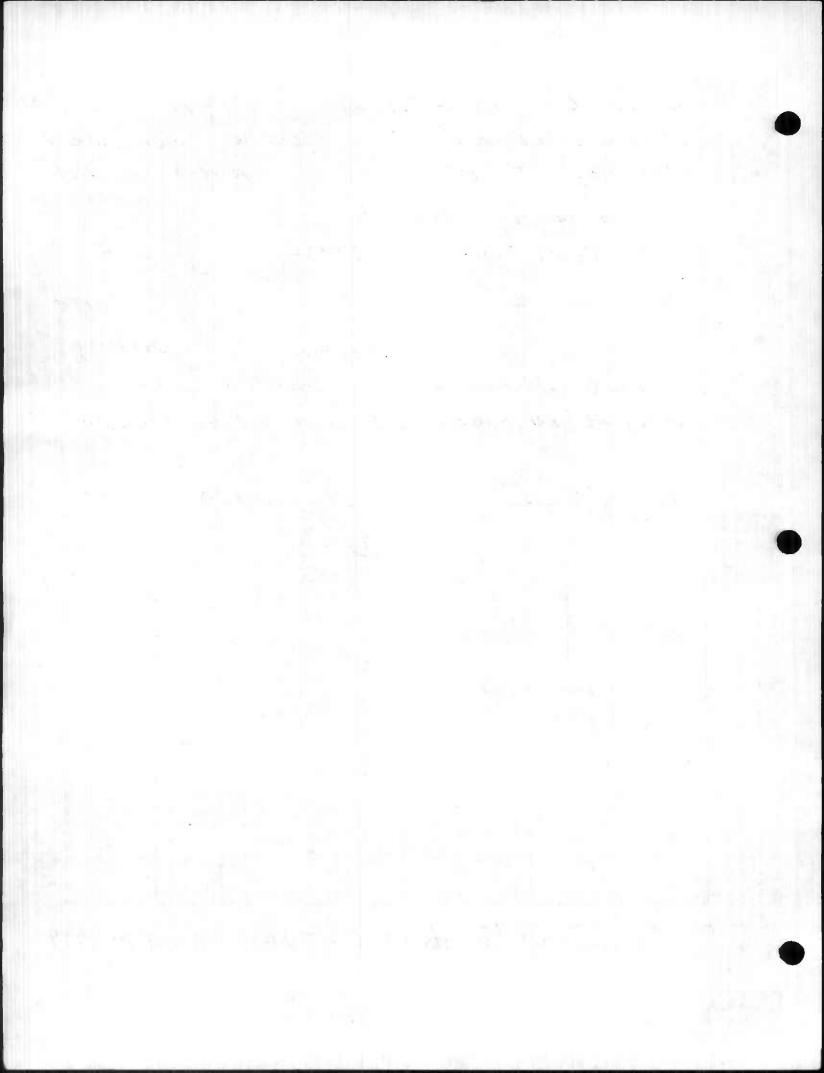
State Registrar

Medical

29e. Certifier

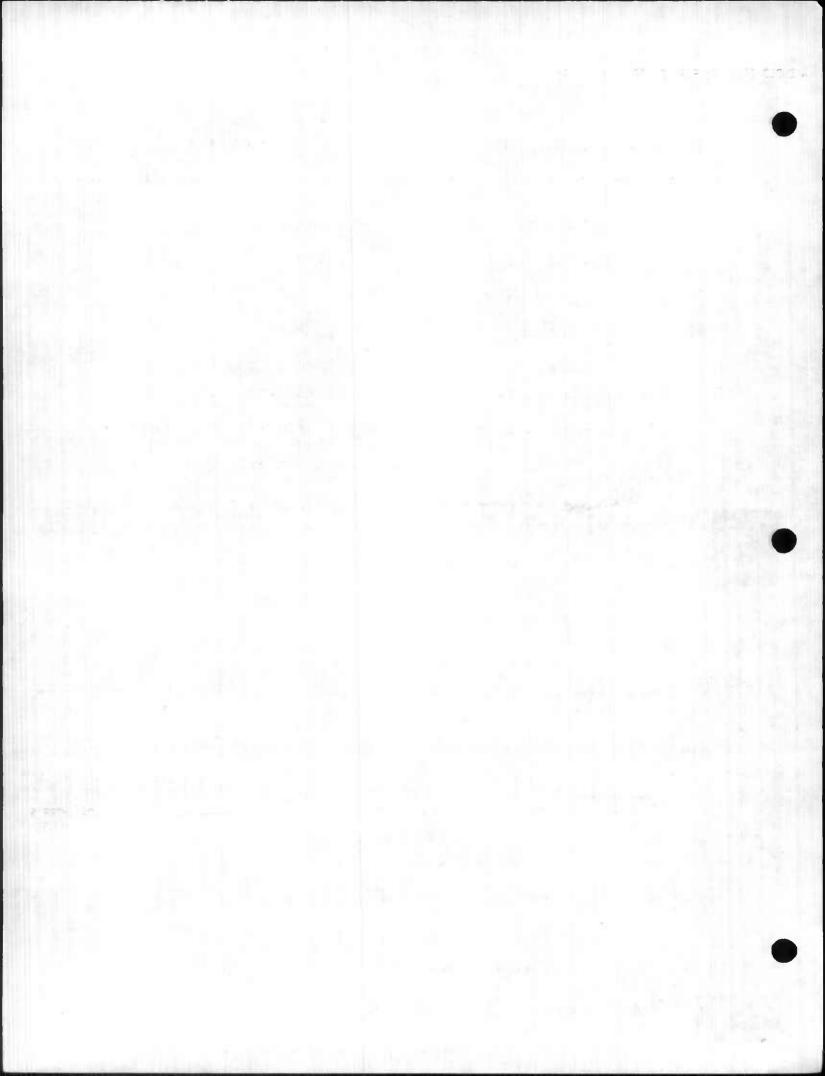
31. Dete filed (Month, Dev. Year)

32. Registrer's Signeture



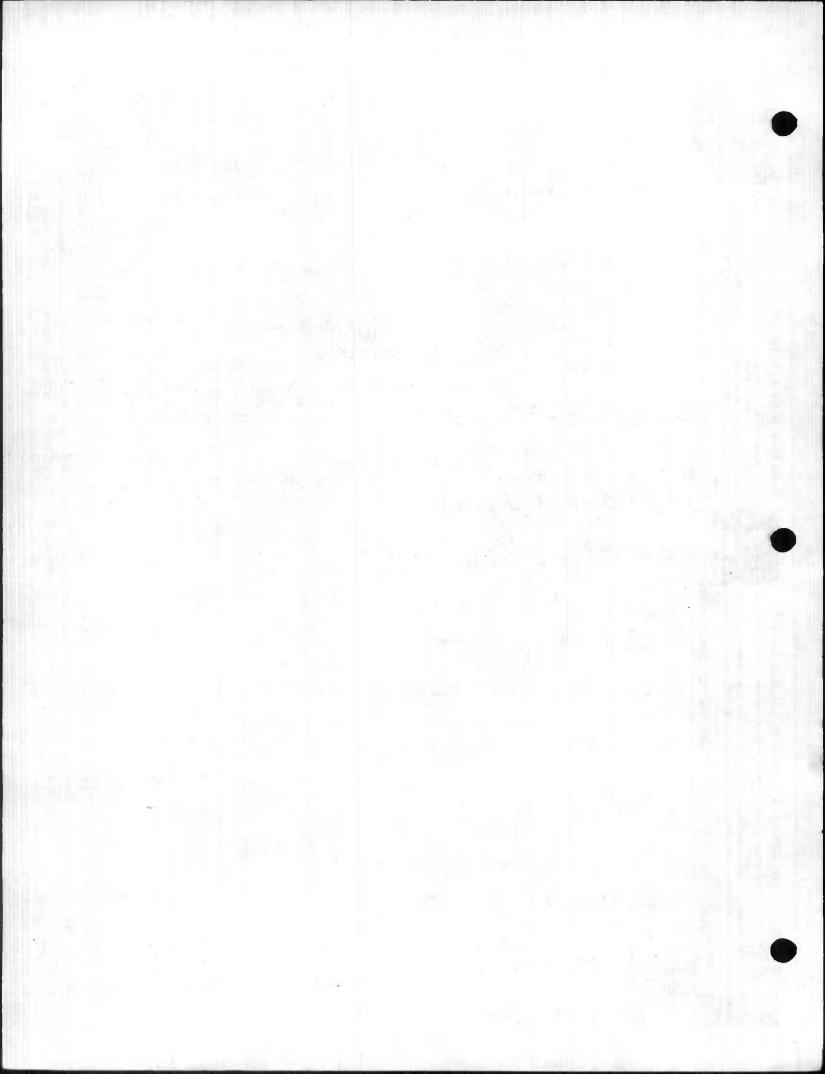
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EM #26 F	ER MD G774 8/30/99 AH	State of Marylan		ent of Health a ate of Death		Reg. No. 99	27133
hysician /Medical	Decedent's Name (First, Middle, Last,	Doris		Stokes	2. Date of I	Day Ye	3. Time of Death 99 11:20 A, M
neral		Hill Ro		OWIN	24 Hrs. 8. Date of E	Ba 1-	
by Funeral Director	215-28-2680 Usual Residence of Decedent		y, Town or Location		1.03	02 311	10d. Inside City Limits
lor			ikesvill				1 ☐ Yes 2 No
Director	MD Balti 10e. Street and Number	more P		Zip Code		10g. Citizen of Wha	it Country?
	3916 Avonhurst	Circle		21208		U,	S.A
The state of the s	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		pedent of Hispanic Ori pecify Cuban, Mexical 2 No Specify:	igin? (Specify Yes or f n, Puerto Rican, etc.)	14. Race	American Indian, White, etc.
	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	sual Occupation work done during mos use retired)	at of working	16b. Kind of Busin	ess/Industry
	12th grade	na	Cleri	T	-d- Marin (Files Affida		Security Ad
	17. Father's Name (First, Middle, Last) John K Matthew 19a. Informant's Name/Relationship (Ty		10h Mailine Adden	Alv	er's Neme (First, Midd erta Your er or Rural Route Nun	ng	ste Zin Code)
	Wanda Bell-Daug 20e. Method of Disposition 1XI Burial 2 Cremation 3 GR 4 Donation 5 Other (Specify)	hter Removel Irom State	9929 Lii	nden Hil lame of r other place)	1 Rd, Ow:	ings Mill 20c. Location - Cit	s, Md 2111
	21. Signature of Funeral Service License	I Ga	22. Name Marc	and Address of Facili	ity		
edical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequence of	n):			Year
Physician/Medi	resulting in death) Last	d	as a consequence of			2	
	Part II. Other significant conditions con History of pan	ntributing to death but not rest		cause given in Pert			bute to the cause of death?
		-			24e. We pe	es en eutopsy formed?	24b. Were autopsy lindings available prior to completion of cause of death?
Completed					10	Yes 2 No	1 Yes 2 No
Certification: To Be	27. Manner of Death 1 SNatural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 1 1 28b. Time of Injury	DOA Other: 4 No	28d. Describ	/	(Specify) DAUGHTER'S HOUSE
	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, lerm, street, facto	1 Yes 2 ory, office	28f, Location	(Street and Number own, Stete)	or Rural Route Number,
edical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	tion and/or investigation	on, in my opinion, dee	nd place, and due to the time	a, date end piece, and	f dua to the cause(s)
IM	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	educas		9c. License number 042178		29d. Date signed (# 8 23 9	
	30. Name and address of person who co	ompleted cause of death (Item 4) 1938 GULLAS	23a) (Type, Print)	2120 Bal	to., MO 2120	8	
ate trar	31. Date filed (Month, Day, Year) AUG 3 0 1999	32. Registrar's Signa	G. Soa	uks			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

The field of the f			State of Maryland / I	Certificate of Death	Reg. No. 99	27134
Engineer Figure 1 Figure 2 Figure 2 Figure 2 Figure 2 Figure 3 Figure 3 Figure 3 Figure 4 Figure			Wanda Stella	Santelli		
Usual Placehores of Decoders 100. Cesty and Placehores 100. Cesty Town or Location (Crofton 100. Special and Number			4a Facility Name (If not institution, give street and number)			
The State 100 Country 100 Country 100 Color 100 Country 100 Color			213-10-3285 1 ^{1 M} 2 ^M F 87	Months Days Hours Min	8. Dete of Birth (Month, Day, Year) 9.1 Oct. 29 1911 M	Birthplaca (State or Foreign Country) (aryland
The standard Developed D		Maryland and alternation	10a. State 10b. County 10c. City, Tow		The Park	10d. Inside City Limits 1 ☐ Yes 2 No
The specific Claims Manager Provided (and Section 1) The specific Claims (and Section 1) The specific		with the the not				
Elementary (0.12) College (1-for 54) Home Maker Own Home	020	ors after aff, or the Examine	11. Marital Status 1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Yes, Give Year or Detes:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.) 14. Race - A Bleck, W	merican Indian, hite, etc.
20b. Place of Disposition 20b. Meghod of Disposition 1(Paurial 2 Clemation 3 Removal from Stete 4(Donation 5 Other (Specify) 21. Signature of Fungers) 22. Nagas and Actives of Facility 22. Nagas and Actives of Facility 23. Signature of Fungers Sancia Longition 23. Signature of Fungers Sancia Longition 23. Signature of Fungers Sancia Longition 24. Nagas and Actives of Facility 25. Signature of Fungers Sancia Longition 26. Nagas and Actives of Facility 26. Nagas and Actives of Facility 27. Nagas and Actives of Facility 28. Signature of Fungers Sancia Longition 29. Nagas and Actives of Facility 29. Nagas and Actives of Facility 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 21b. Signature of Fungers Sancia Corresponders 22c. Nagas and Actives of Facility 27c. Nagas and Actives	21215-0	Pan Ban	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) R NA	(Give kind of work done during most of wo life. DO NOT use retired)	rking	
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Physician Physic		~ 1 1 1	20a. Method of Disposition 1 © Burial 2 © Cremetion 3 © Removel from Stete	f Disposition (Name of ry, cremetory or other place)	Sept. 20c. Location - City	or Town, Stete
Physician (Modical Examiner The deficiency particles of the disease, or complications that death. Do not enter the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, increased the mode of dying, such as cardiac or respiratory errest, provided as a consequence of): Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Due to (or as a consequence of): Due to (or as a consequence of): 1 Vea 25No 3 Probably 4 Unknown or resulting in the underlying cause given in Pert I. 1 Vea 25No 3 Probably 4 Unknown or resulting in the underlying cause given in Pert I. 1 Vea 25No 3 Probably 4 Unknown or resulting in the underlying cause given in Pert I. 1 Vea 25No 3 Probably 4 Unknown or resulting in the underlying cause given in Pert I. 2 S. Was case referred to medical examiner or resulting in the underlying cause given in Pert I. 2 Veal 25No 3 Probably 4 Unknown or resulting in the underlying cause given in Pert I. 2 Veal 25No 3 Probably 4 Unknown or resulting in the underly	Balti	Departir Departir Imports any Inju	21. Signature of Funeral Service Licepton Commission Co			
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	1	Ohusisian	23a. PArt. Enter the disease, or complications that a used the deeth. Do shock, or heart failure. List only one cause of each line.			Approximate Interval Between
Cause (Disease or injury) The control of the state of the		/Medical Examiner	resulting in death) Due to (or as a	· · · · · · · · · · · · · · · · · ·	ve	3 months
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The state of the s	. 80	e attended for un	Pert II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Pert I.	23b. Did tobacco use contrib	uta to the cause of death?
24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. Ware autopsy findings evaluable prior to completion of cause of death? 1 Yes 2 No 2 No 1 Yes 2 No 2 N	σ.	5 50			1 □ Yes 2 1 No 3 □	Probably 4 Unknown
25. Was case referred to medical examiner?	ecord					evailable prior to completion of cause
1 1 1 1 1 1 1 1 1 1	=	in: The ifficate to or, page		26 Plane of De		1 Yes 2 No
1 Natural 2 Accident 3 Suicide 4 Homicide 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Pec of Injury At home, ferm, street, fectory, office 2 St. Location (Street and Number or Rural Route Number. City or Town, Stele) 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Sheck only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)	Ž	nyelola nis cert i direct	Hospitel: 1 I Innertical 1 I Innertical	utpatient 3 DOA Other: 4 Nursing		Specify)
29e. Certifier (Check only 20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29e. Certifier (Check only 20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29e. Signature end title of certifier 29e. License number 29d. Date signed (Month, Day, Year) 29e. Certifier (Check only 20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29e. Signature end title of certifier 29e. License number 29d. Date signed (Month, Day, Year)		After fune	27. Manner of Death 1 7 Natural 5 Pending (Month, Day Year) 2 Accident investigation 2 Suided 6 Could not be	M 1 Yes 2 No		
Wayne Bustain, mg 038563 august 28, 1999	N N	its offer At rel Direct led in by		street, fectory, office		Hurai Houte Number,
Wayne Bustain, mg 038563 august 28, 1999		n 24 hou se Fune pletaly fil	29e. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge of the control of the con			
		To the		29c. License number 0 3856 3		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) ONENSUILLE RA II	last River Mr	
State Registrar AUG 3 0 1999 State Registrar			31. Date filed (Month, Day, Year) 32. Registrar's Signature	South!	7. A.1A.1	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #10C, E,F, 15, 19B PER State of Maryland / Department of Health and Mental Hygiene 99

AMENDED ITEM #1 PER MD 6776 10/01/99 AH

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death MARGARET_LORETTA TURNER Month **Physician** 15 pm /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ARNOLD CARRE Chepa peake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) /2 -27 - 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours 219-16-0376 **Director** Usual Residence of Decedant the Maryland 10a. State 10b. County ahow 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at A. A ARNOLD MD Director **ANNAPOLIS** 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 FOREST BEACH RD Nems 23s or USA RRIVITO 7E9E Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, afc.) 11. Marital Status 14. Race - Amarican Indian, 12. Was Decedent Evar in U,S Armed Forces Black, White, etc. filed within 72 hours after 1 ☐ Yas 2 No If Yes, Give 1 Nevar Married 2 Married 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: BLACK p 3D(Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiena. Important: If Item 27 is marked other than any Injury or other traumatic avent, the Many Injury or other traumatic avent. Elementery/Secondary (0-12) College (1-4or 5+) BOOKKEEPER EDERAL Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERNARD SADIE MNDERSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/40/6/19 19 FOREST BEACH RO ANAROLIN, MD 19a. Informant's Name/Relationship (Type, Print) brAllE19100KS ()Aughter 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses 22. Name and Address of Facility MD anaul Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final end stage rend disease or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner betes ia The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. ser tensi Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records, Be Completed by page 2 should be 24b. Were sutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? dementia 1 Yes 2□ No Division of Vital or Attanding Physician: 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) 1 ☐ Yas 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Affer 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after deatl To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At homa, farm, streef, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 479

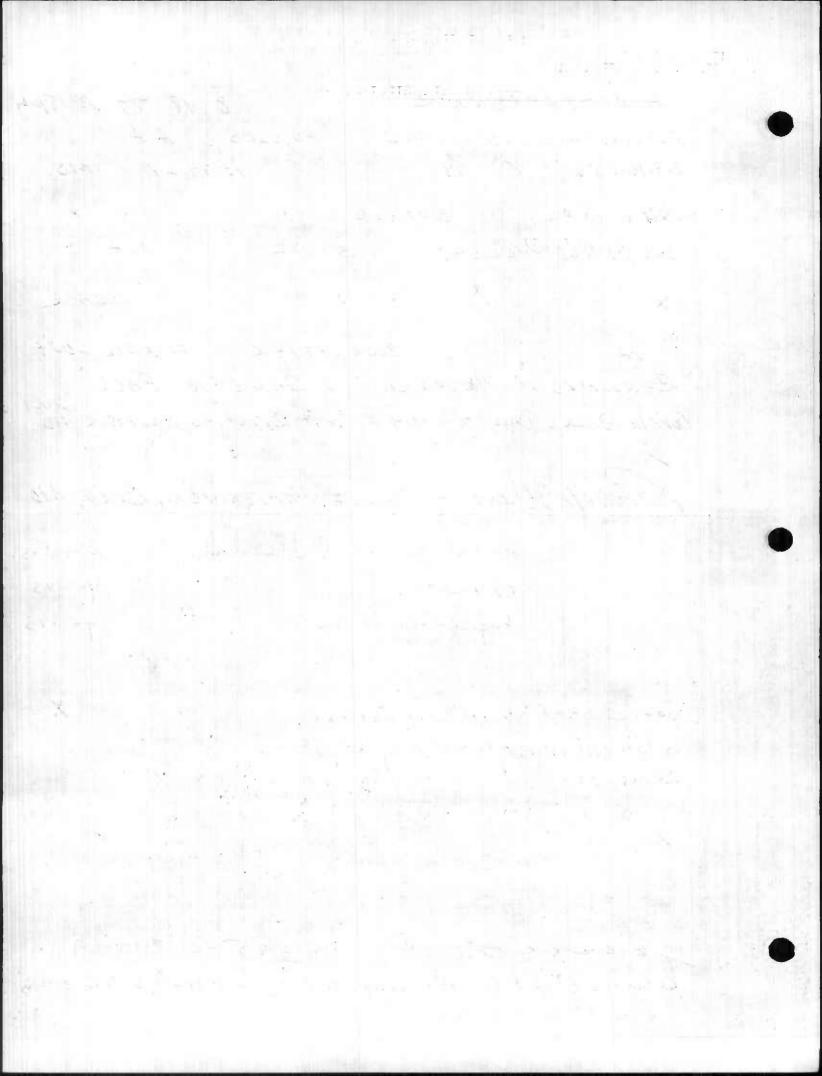
32. Régistrar's Signature

Tumpers Hole Rd Severna Park MD 21146

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2/0

31. Date filed (Month, Dey, Year) AUG 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dev Year **Physician** Burhan Uddin 1999 AUGUST 28 1:54 A /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE If Under 24 Hrs. Houra Min. Dete of Birth (Month, Day, Year) 6-6-1962 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Deys MXM 2□ F N/A 37 Pakistan Director Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahon traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Essex Md the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Нета 23а 21222 Pakistan 1616 4 Georges Court Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yea 2 Û No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Wea Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic avent, the Medical Exempted. 1 Never Merried Merried Baltimore, Maryland 21215-0020 Specify: Asian 1 ☐ Yes 2 XXNo Specify 5 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sicily Pizza Elementary/Secondery (0-12) 12th grade College (1-4or 5+) Driver N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Taibar Sultana Ahmed 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Poughkeepsi, N.Y. 12603 Sardar Ali-Cousin 18 B Rhobella Drive 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 9-2-99 4 ☐ Donation 5 ☐ Other (Specify) Swat, Pakistan Deolai Cemetery 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility
March F/H West Warren and 4300 Wabash Avenue Baltimore, Md 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heef feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Gunshot disease or condition resulting in death) Wound Examiner Due to (or as a consequence of): Examiner that the death certificate be executed physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or ea a consequence of) 980 0 P.O. Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert It. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yae 22 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Wes an autopsy parformed? Completed page 2 1ÆYes 2□No 1 ØYes 2□ No Division of Vital or Attanding Physician: 25. Was case referred to medical axaminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ◯ DOA this 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After Injury 1 Netural 5 Pending death. 1 XYes 2 □ No investigation 8-28-99 2 Accident Shot n 24 hours after death ve Funeral Director: / pietely filled in by the f 120 Subject Was 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1800 black Dalles 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Car | Street | Baltimere City, Manylang |

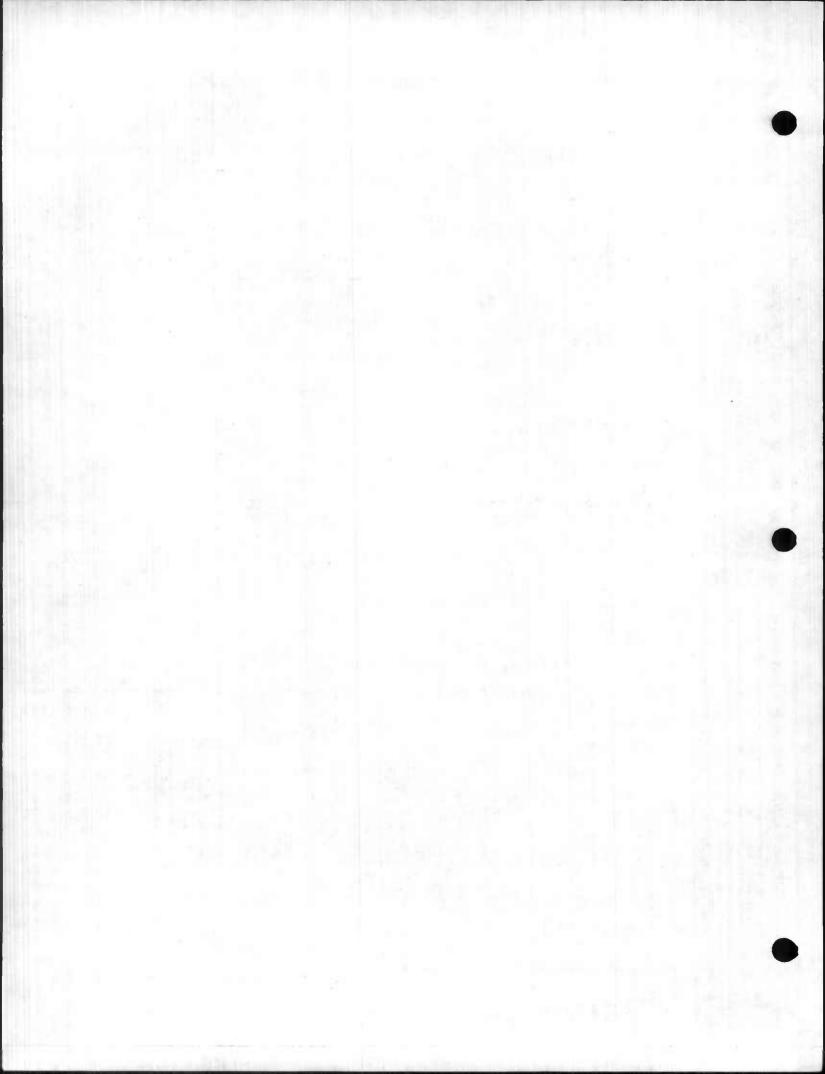
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Hospital edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E AUGUST 28,1999 30. Nama and address of parson who completed cause of death (Item 2001 (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 R Strohen S. adentz filed (Month, Day, Year) AUG 3 0 1999 32. Degistrer's Signeture State

DHMH 16 Rav 6/95

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Evelyn Bower Weiss 08 28 1999 09:20pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore H Under 24 Hrs. 8 Towson 8. Dete of Birth (Month, Day, Year) June 21, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Days Hours Maryland Months 213-18-7471 76 Director Usuel Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland 288-0 Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. 2 Fox Leighgreen Rd. 21093 238 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Status Bleck, White, etc. 1 Never Married 2 Merried ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18 Mother's Neme (First Middle Maiden Surneme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental James William Bower Catherine Mann 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1035 Parksley Ave. Baltimore, Md. 21223 Stephen Weiss - son reportant: if Item 27 ny Injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Deurial 2 □ Cremetion 3 □ Removal from State Evergreen Mem. Gardens Aug. 31,1999 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
Eckhardt Funeral Chapel 21. Signeture of Funerel Service Licensee 11605 Reisterstown Rd. Owings Mills. Md. 21117 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** VENTRICULAR ARRHYTHMIA /Medical Immediate Cause (Final disease or condition resulting in death) SMINUTES Examiner Examine 140 CARDIAL HOURS Sequentially fist conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): USe Pert ff. Other stanfficant conditions contributing to death but not resulting in the underlying cause given in Pert I, 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably Unknown Records. þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. tnjury at Work? Naturel 5 Pending 1 Yes 2 No death. Accident investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as atlated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier (Check only one) within 2 eg: 29d. Date signed (Month, May, Year) 29b. Signature and site of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD. 21204 SILVERT 6701 51. 50 N CHARLES KEITH 30 32. Registrer's Signature State 1999 Registrar

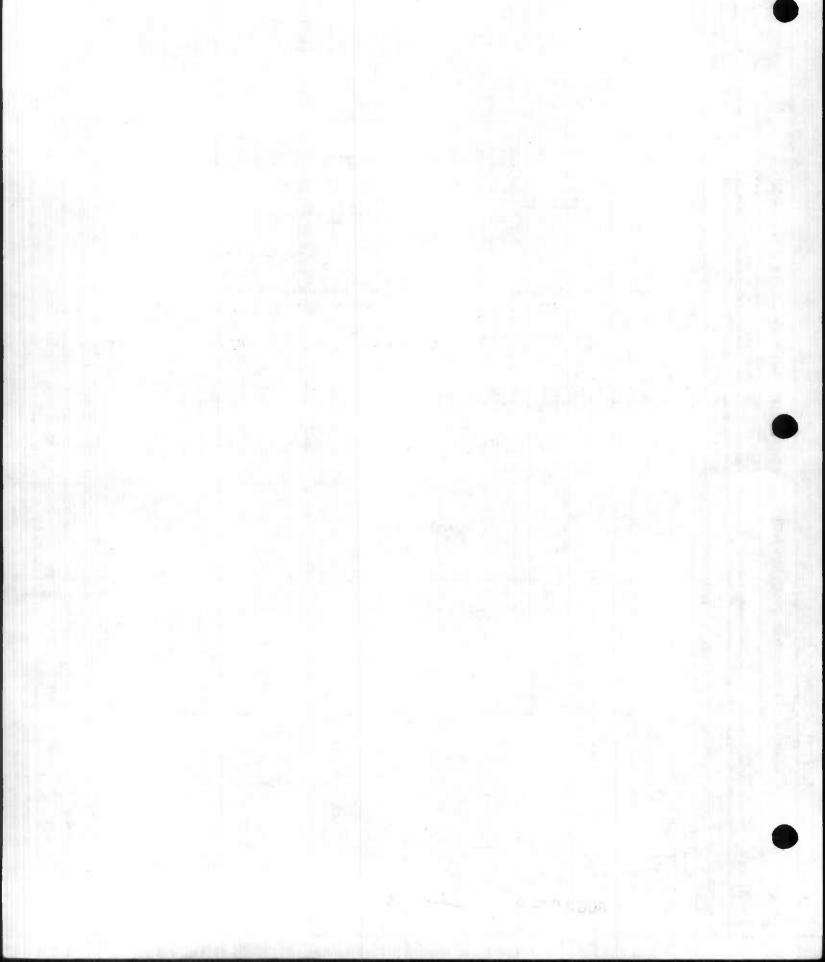
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State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle	s, Last)		00/11/	ficate of	J-04(1)	2. Date of Dec			3. Time of Death
sician	AARON				WALDE	.V	AUGUST	26, 199	Year	7:05 PM
dical niner	4a Facility Name (If not institution	n, give street and numi	ber)			4b. City, Town, or I	1	1		
	SUBURBAN HOSP	ITAL				BETHESDA		YIMOM	SOMERY	
l r	5. Social Security Number 414–58–4637	6. Sex 7	Age (In yrs.	N	Under 1 Year lonths Days		8. Date of Birt (Month, Da AUG • 1	y. Year) 1916	9. Birthplac Country)	D.C.
	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Locat	on				10d.	. Inside City Limits
0	MD MONTG	OMERY		ROCKVIL	LE					1 ☐ Yes 2/7/No
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	7
Funeral Di	5901 MONTROSE	ROAD #308	SOUTH			20852	-6.12	U.S.A.		
	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 K Yes 2 If Yes, Give Year or Dat	es?	111	Decedent of es, specify Cut	Hispanic Origin? (S san, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Ble Specif	ce - American ck, White, etc.	
	15. Deceden		7110	16a. Deceden	's Usuel Occu	pation		16b. Kind of B		
	(Specify only highes Elementary/Secondary (0-12)	ct grade completed) College (1-4	lor 5+)	(Give kin life. DO TEACHER	NOT use retire	during most of wor od)	king	EDUCA:	PTON	
ı	17. Father's Name (First, Middle,	1		TUNCTION		18. Mother's Nan	ne (First, Middle,			
	NATHAN			WALDEN		NETTIE			(UNKN	JOWN)
	19a. Informant's Name/Relations			Address (Stree	t and Number or Ru	ral Route Numbe	er, City or Town			
	BESS WALDEN /	WIFE		5901 M	ONTROS	E RD #308	S RC	CKVILLE	E, MD 2	20852
1	20a. Method of Disposition 1X Burial 2 ☐ Cremetion	2 [Dame of the C		Plece of Disposition	on (Name of bry or other pla	ice)	Data	20c. Location	- City or Town	, Stete
	4 Donation 5 Other (S)			EVRA AHA	VAS CHE	SED	8/27/99	RANDAI	LISTOWN	I, MD
I	21. Signature of Funeral Service	igensee /	`		eme end Addr	S	OL LEVIN			
+	23a. Part J. Editor the chaese, or shock, or head failure. List	complications/that car	ised the deer			TERSTOWN				pproximete tervel Between
CARITITION	Immediate Cause (Finel disease or condition resulting in death)	a. AS		or as a conseque	nce of):	2umoi	nia		h	veeks
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с		or as a consequer						
		d							1	
	Part II. Other significant condition	ne contributing to dea	th but not res	not resulting in the underlying cause given in Part I.				obacco use co	ontribute to th	ne cause of death
ı	-						10'	Yes 2 No	3 Probab	bly 4 Winknow
								en autopsy med?	availa	autopsy findings able prior to eletion of cause ath?
							101	res 200 No	1 D Y	res 21XNo
	25. Was case referred to medical examiner?	Hospital:			10		ith (Check only o	ne)		
	1 Yes 201 No	1 1/25,100			3U DOV		lome 5 Resid			
	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	pation not be		1		rk?]Yes 2□No	28d. Describe I			
	4 Homicide determ	ined 206. Place of building	, etc. (Speci	ome, ferm, street. fy)	rectory, omce		28f. Location (\$ City or Tox	vn, State)	oer or nurar n	oute Number,
	29a. Certifier (Check only one) 1 Certifying 2 Medical I	g Physician: To the be Examiner: On the bas and manne	is of examina	owledge, death oc ation and/or invest	curred at the ti igation, in my	me, date and place opinion, death occu	, and due to the orred at the time,	cause(s) end m date and place,	enner as state and due to th	ed. a cause(s)
E 1	29b. Signature and title of certifier		D /	2	29c. Licen	se number		29d. Date signe	ed (Month, Day	y, Year)
	** Katha 30. Name and address of person Katharine 7	rine ?	R. Z	illie m	40	D532	.44	Augus	+ 26,	1999
	30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type, Prir	11)	11 01	. 4 10			- 0-05
	Katharine 7	R. Lillip	MD	11140 F	COCKV	HE FIKE	e #348	, ROCKV	ille, M	D 2085.



State Registrar 30. Name and add

nth, Day, Year)

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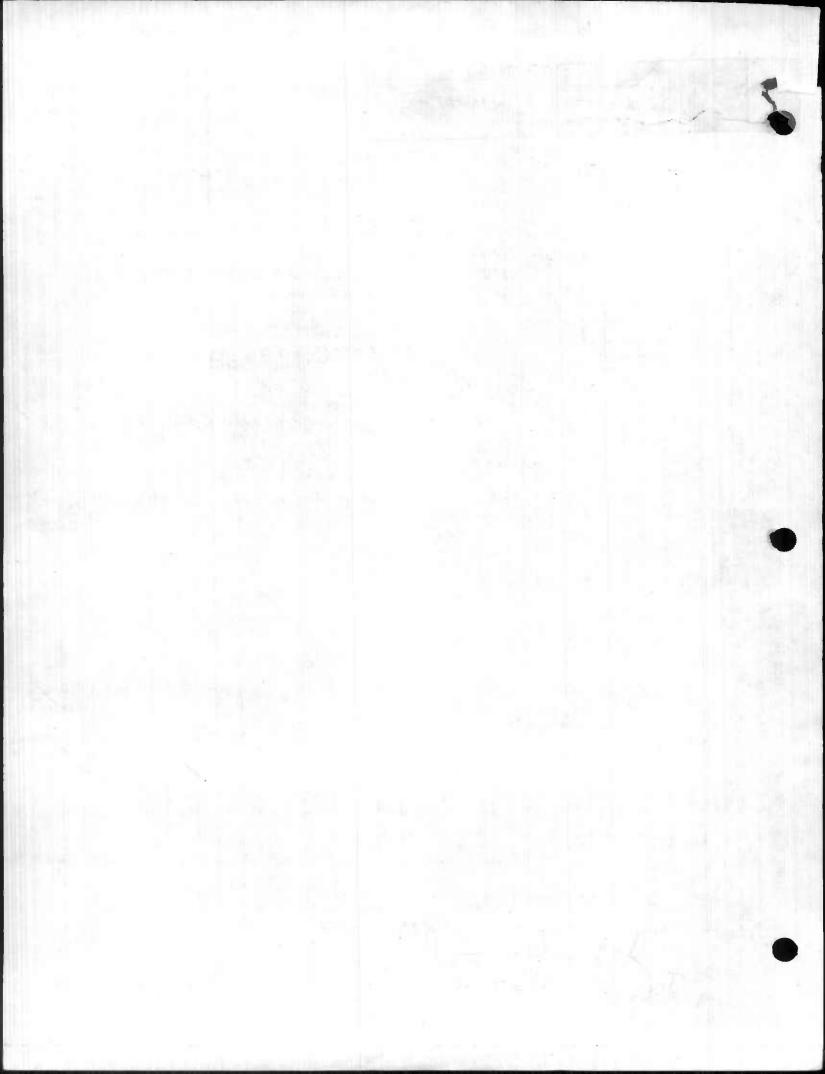
DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

Beneva



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #20b PER FH G774 8/30/99 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 pm **Physician** Watson llugust /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Deaton mivers. ty Maryland Medic. Baltimore (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age Months Days Min NØM 2□F 244-68-2637 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 7 is marked other than "naturel", or items 23s or treumstic event, the Medical Expresses must be a ,5.F 5 Chartes Street 611 21230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S Armed Forces? Biack, White, etc. I ☐ Yes 2 D(No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Black 1 ☐ Yes 2 No Specify p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) W.R. Grace Co. 12 should be filed within h and Mental Hygiane. 'Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) hemical WorkLer NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Watson Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Falls Bridge Drive 4402 Da Ho, Md 21211 Department of Health mportant: If Item 27 Wayson 4ha 20b. Place of Disposition (Name of ARBEN OF cemetery, cremetory or other place) ETHSEMANE 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kocky 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility 1arch F. H. lade 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, Md Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be axed Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): USe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Winknown 1 ☐ Yss 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? or Attending Physician: HAPLE A6. Flace & peach (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) funaral 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? Certification: 5 Pending Investigation 2 □ No death. 1 ☐ Yes 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

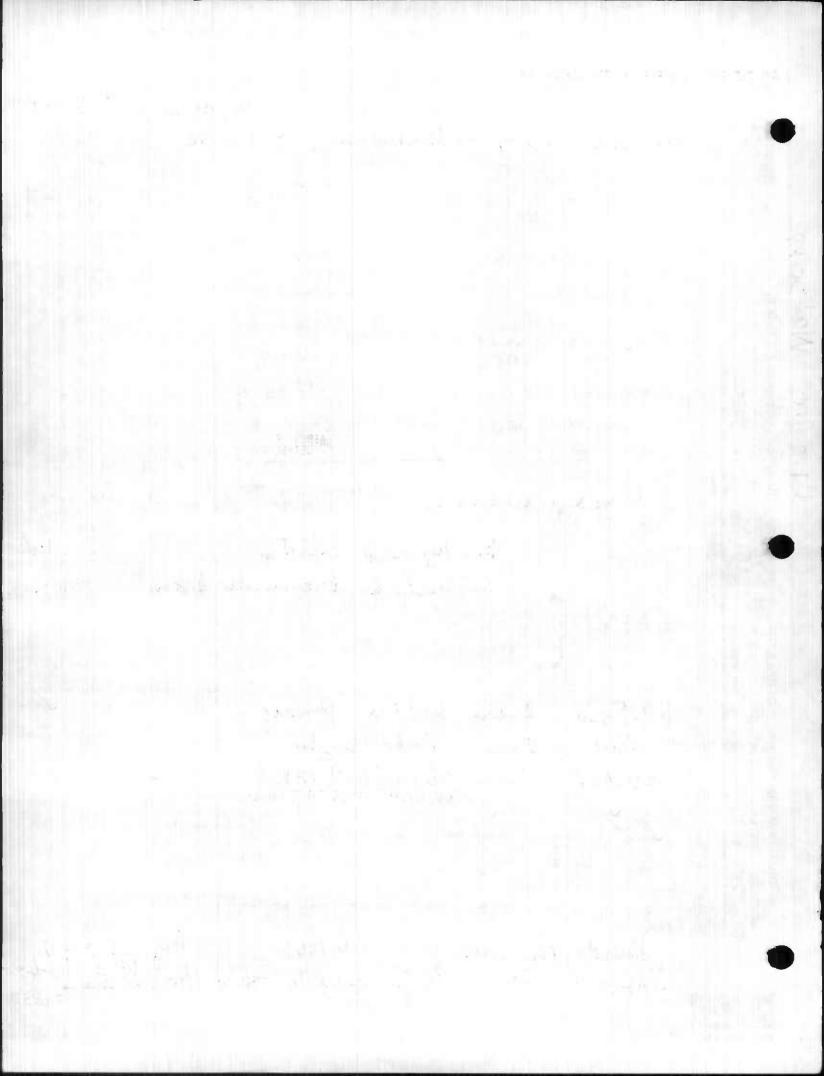
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 23d Date signed (Month, Day, Year)

ad cause of death (Item 23a) Type, Print)

32 Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

AUG 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #18 PER FH G774 8/30/99 AH 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath Hugas **Physician** Inna OUNG /Medical 4a. Facility Nama (If not institution, gly City, Town, or Location of Death 4c. County of Daath street and number Examiner atonsulle Orest Haven Balto 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funerai** 96 Days 214-14-1084 Yrs Director Usual Rasidanca of Dacadant tha Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at NA 1 Yas 2 No Director 1tim one 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 124 120 Herns 23a , S.H Funeral Was Decedant of Hispanic Orlgin? (Specify Yas or If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status Armed Forcas?

1 Yas 2 Yano
If Yas, Giva
Yaar or Datas: 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify Specify: à 3 Widowed 4 ☐ Divorced Black Completed 15. Decedant's Education 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry grada complated) permit. Pagas 1 and 2 should be filed withir Department of Haalth and Mental Hygiane. Important: If item 27 is merked other than any Injury or other traumatic event Elementary/Secondery (0-12) College (1-4or 5+) 12th NA Tailor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Butcher Smith IDA GERTRUDE MABEL 19b. Mailing Address (Straat and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 20024. 19a. Informant's Name/Reletionship (Typa, Print) Delaware Ave Daniels-Daughter Dorothy Washington D.C. N.W. 20a. Mathod of Disposition 20b. Placa of Disposition (Nema of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 21. Signatura of Funaral Sarvice Licansaa 23a. Part1. Entar tha disease, or complications that caused tha death. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Sa 140, Approximate Interval Batween Onsat and Death **Physician** Corbiou poular diseas /Medical Immadiata Cause (Final disaasa or condition rasulting in daath) Examiner Dua to (or es a consequença of) Examiner burial-transit Sequantially list conditions, if any, laading to Immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in deeth) Last Dua to (or as a consequence of): physician Physician/Medical Dua to (or as a consaquanca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 INO 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of causa of death? Be Completed 24a. Was en eutopsy performed? page 2 s 1 ☐ Yas 2 ☐ No cartificata Division of Vital To the Hospital or Attending Physician: within 24 hours effer daath.

To the Funeral Director: After this cartifica completely filled in by the funeral director; p 25. Was casa referred to medical 26. Placa of Death (Check only one) axaminar Other: 4 United Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 ☐ Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Data of Injury (Month), Day 28b. Tima of 28d. Dascribe how injury occurred 1 Neturel 5 Pending invastigation 1A 1 | Yes 2 No 2 Accidant 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

AUG 3 0 1999

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Nama and addrass of person who co

29b. Signature and put of certifie

31. Data filed (Month, Dey, Yaar)

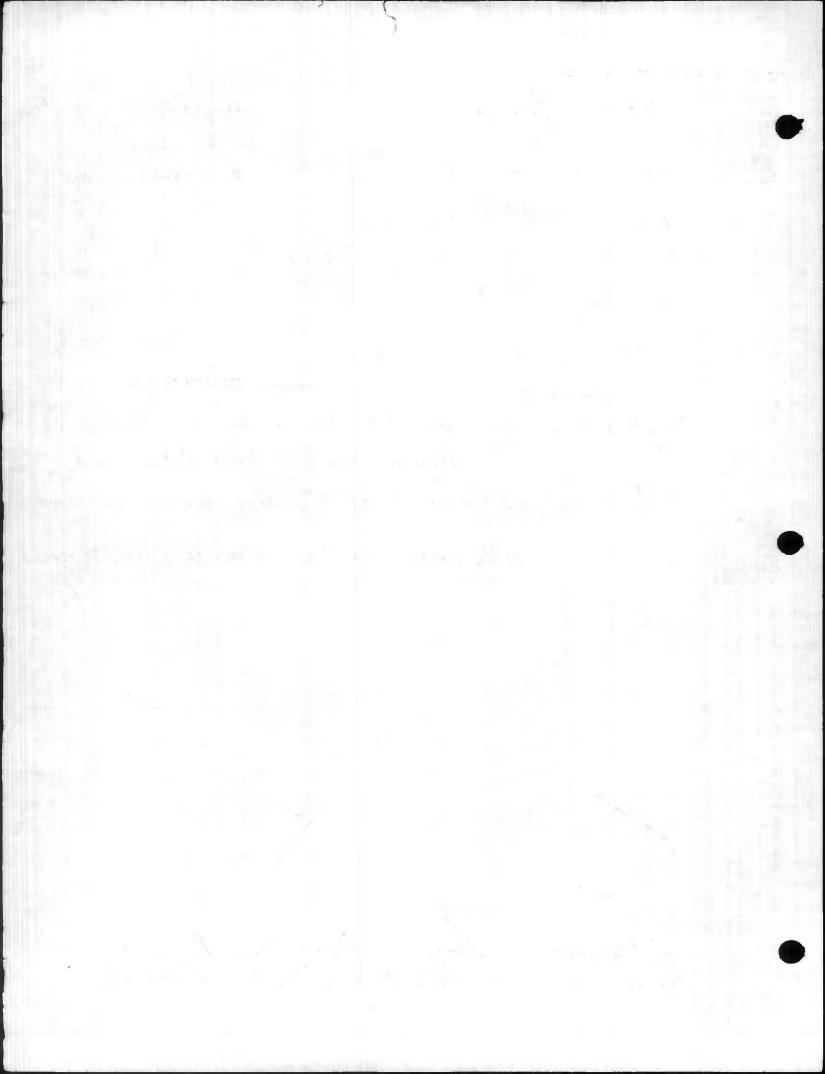
32. Registrer's Signatura

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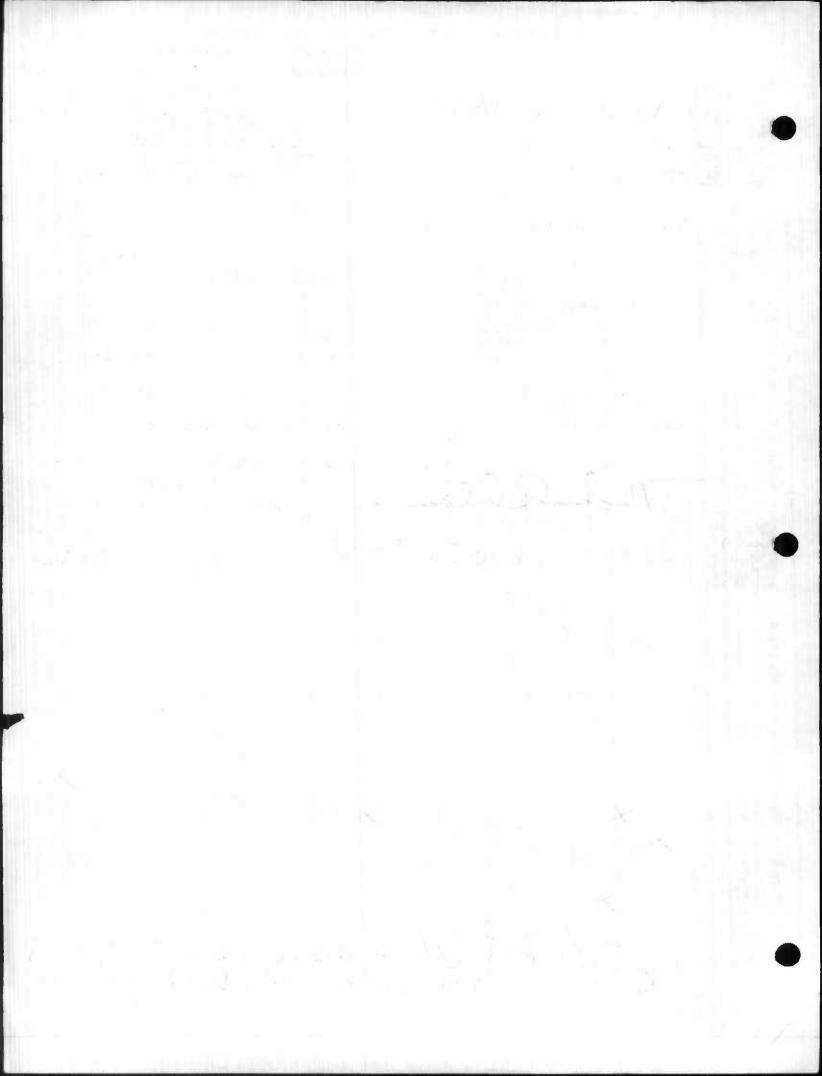
29c. Licansa number

29d. Data signed (Month, Day, Year)



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				ar y rarre	-	ificate of	Death		Reg. No.	5	7142		
Physi									Year	3. Time of Deeth			
/Med Exam		4e. Fecility Neme (If not institution, give	4b. City, Town, or	August Location of Deeth	12,	1999 of Deeth	7:55 AM						
LXaiii	II ICI	Shady Grove Ad	ventist	Hosp	ital		Rockvil	le MD	Mon-	tgome	erv		
Funera Directo		5. Social Security Number 6. Se 578-64-0836	If Under 24 Hrs Hours Min	8. Dete of Birth 9. Birthpiece (State or Fo			ece (State or Foreign try)						
/land		Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location											
the Marylan r 28a-f show	ctor	Maryland Montgomery Gaithersburg 10b. County 10c. City, Town or Location 10d. Inside											
or 28	Director	10e. Street end Number	10f. Zip Code						10g. Citizen of \	Whet Count	try?		
9th w	ra.	9701 Fields Road	8		Unite	d Sta	tes						
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21215-0020 d within 72 hours aft giena.	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	r 5+) 16a. Decedent's Usuel Oc (Give kind of work de lite. DO NOT use re Vice Pres			Occupation done during most of working		16b. Kind of Business/Industry				
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and 2 be filed stall Hygir d other	BeC	17. Fether's Neme (First, Middle, Last)			VIC	- IICSIC		Insurance Company s Neme (First, Middle, Maiden Surname)					
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re, Maryla s 1 end 2 should f Haaith end Men tem 27 is marke	1	19e. Intorment's Name/Reletionship (T	ype, Print)		19b. Meiling	Address (Stree	end Number or R	ural Route Numbe	er, City or Town,	State, Zip	Code)		
		Kevin Afshar/Son		ook Di-			, Bethes						
Peges 1 er rent of Haa nt: If Item		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ I	Removal from State			lon (Name of tory or other pla	1	Dete	20c. Location -		10000		
Baltimore, permit. Peges 1 er Depertment of Heal Important: If Item 2 any Injury or other		4 Donation 5 Other (Specify) National Memorial Park 8/15/99 Falls Church, Virginia											
E E E		22. Name and Address of Facility DeVol Funeral Home. 10 East Deer Park Dr., Gaithersburg, MD. 20877											
		23e. Pert1. Enter the disease, or comp	llcations thet caused	the deeth.	Do not enter	East De the mode of dyi	er Park . ng, such es cardie	Dr., Gai c or respiretory er	thersbu: rest,				
Physician	_	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Brown Approximate Interval Between Onset end Deeth OR Year											
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Of Phys this	ition: To	27. Manner of Deeth 1 Matural 5 Pending P Accident investigation	Hospital: 1 Inpatient 2 ER/Outpetient 5 OA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Yeer) 28b. Time of Injury Month, Day Yeer) 28c. Injury et Work? 1 Yes 2 No								")		
D 5 5 5 5	Certification:	3 Sulcide 6 Could not be determined	building, efc. (Specify)						28f. Location (Street end Number or Rural Route Number, City or Town, State)				
Hospital 24 hours Funeral I	edicai	29a. Certifier Cartifying Phy (Check only one) Cartifying Phy	stcian: To the best of ner: On the basis of	examinetic	edge, death o	ccurred et the ti	me, dete end plece opinion, deeth occ	e, end dua to the urred et the time,	ceuse(s) and me date end plece,	enner as ste and due to	eted. the cause(s)		
To the within To the comple	Med	29b. Signeture end title of mining and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)											
7		30. Neme and eddress of person who co	ompleted cause of de	eeth (Item 2	23e) (Type, Pri	int) Doc	N 1	201	7/1	(1)	10/11		
	ate	31. Dete tiled (Month, Dey, Yeer)	32. Begistre	or's Sinnatu	181	1) KIN	a hou	DVI,	Olu	J 15	1) auss)		
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	#23 PART I	27 PER	MEO G775 9-	7-99 WR.	Cei	rtificate of	Death	2. Date of Deat	eg. No.		3. Time of Death	
cian dical	1. Decedent's Neme (First, Middle, Last) John Phillip Albert							Month August	Day 10	Year 1999	02:37 PM	
iner	4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death											
	118 Limestone Road 5. Social Security Number 6. Sex 7. Age (In yrs. les					If Under 1 Yeer	Hancoc If Under 24 Hrs.			shington		
al or	031-36-5640 188 M 2□ F 52 Usual Residence of Decedent				Yrs.	Months Days	Nov. 5,	8. Date of Birth (Month, Dey, Year) Nov. 5, 1946 9. Birthplace (State or F Country) Massachuese				
	10a. State	10b. County		10c. City, Town or Location						10	Od. tnside City Limits	
cto	Maryland	Montgo	mery Gaithersburg								1 ☐ Yes 2 ☒ No	
Directo	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?			
	18706 Ca	pella La				20877			United			
by Funeral		Arme		⊠ No		Wes Decedent of Hispenic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:			No- 14. Race - American Indian, Black, White, etc. Specify: White			
pet	/C==	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ina	16b. Kind of Business/Industry				
Completed	(Specify only highest grade completed) (Give kind of work done during mo						d) auring most or work	rig				
S				F	Compu	uter Programmer			Computer			
ã	17. Father's Name		nst)				18. Mothar's Nam		Maiden Suman	ne)		
2	Irving A		. C		101 11 11		Phylis B	Bliss Jural Routa Number, City or Town, Stata, Zip Code)				
	19a. Informant's Na						Lane, Gai					
-	Donna M. 20a. Method of Disc		(Wife)	20b. P	lace of Dispo	sition (Name of		T	20c. Location			
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	21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility DeVol Funeral Home 10 East Deer Park Drive											
	Cobord State Composition Composition											
Examiner												
edicai	Cause (Disease or trijury that initialed events resulting in death) Last Dua to (or as a consequence of):											
Icla	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t.								23b. Did tobacco use contribute to the cause of de			
by Physician/M									1 Yes 2 No 3 Probably Unknow			
Completed								24a. Was a perform		ava	re autopsy findings aliable prior to appletion of cause death?	
СОП								1)XV	s 2 No	1)	Yes 2□ No	
	25. Was case references	red to medicet					26. Place of Deat	h (Check only on	a)	1		
5	1 Yes 2		Hospital: 1 inp		ER/Outpatien		4 Li Nursing Ho	ome 5 Reside		ner (Specify) Scene	
Certification:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigated Could no	tion t be	Day Year)	28b. Time of Injury	Wor	yai k? Yes 2□No	28d. Describe he			I Route Number	
Certi	4 Homicida	determin	building	, atc. (Specify)			City or Town				
edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and dua to tha ceusa(s) and mannar as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29c. License number							2	29d. Dete signed (Month, Dey, Year)			
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)	- me	one el					01111				1 2000	
)	30. Name and addre		no complated cause		,	Print)					1 2000	
	30. Name and address THE COLL 31. Date filed (Mont	E Milyng			Penn S	Print)	altimore,	Marylar			1 2000	

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🎐 🤉 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Day August 12
4b. City, Town, or Location of Death 46 Lydia Z. Albertson 1999 3:40 PM 4c. County of Death 4a Facility Name (If not institution, giva street and number) Montgomery General Hospital Montgomery 8. Data of Birth (Month, Dey, Yaar) # Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Months Days Min 1□ M 25 F Yrs. 579-26-6472 91 Nov. 25,1907 Washington, D.C. Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYAS 2 THO Maryland Montgomery Silver Spring 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 3330 North Leisure World Boulevard 20906 USA 14. Race - American Indian, 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) Biack, Whita, etc. 1 ☐ Yes 2 ☑ No ff Yas, Give Year or Dates: 1K Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decadent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Librarian Library of Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George H. Albertson Mabel Elizabeth Edson 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 17310 Parson Grove Olney, Maryland 20832
Loc of Disposition (Name of Date 20c. Location - City or Town, State J. Stanton Boteler (nephew) 20b. Ptace of Disposition (Neme of cematary, crametory or other plece) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/16/99 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Servica Licansee 500 University Blvd., W., Silver Spring, MD 20901 done ever 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, ahock, or heart failure. List only one cause on each line. Approximata Intervai Batween Onset and Death Immediate Cause (Final disease or condition rasulting in death) ~ Kia CO as a consequence of): Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated avants Due to (or as a consequence of): Dua to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause, average Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be axecuted attending physician and for use as the burial-transit

Box 68760.

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Records,

To the Hospital or Attending Physician:

Physician/Medical Examiner

by

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Certification:

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Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example must be not the done.

ed by the a signed by ti peed certificate has the sirector, page 2 s this funeral After n 24 hours after death.

Funeral Director: Aft bletaly filled in by the fur

25. Was casa rafarrad to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be 3 ☐ Suicida 4 Homicida

28a. Date of Injury (Month, Dey Year)

ner: On the basis of exc

28b. Time of 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 🗹 Certifying Physician: To tha best of my knowle 🐽 bath occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

(Check only one)

29a. Certifier

29¢. License number

29d. Date signed (Month, Day, Year) 9

and address of person 23a) (Type, Print)

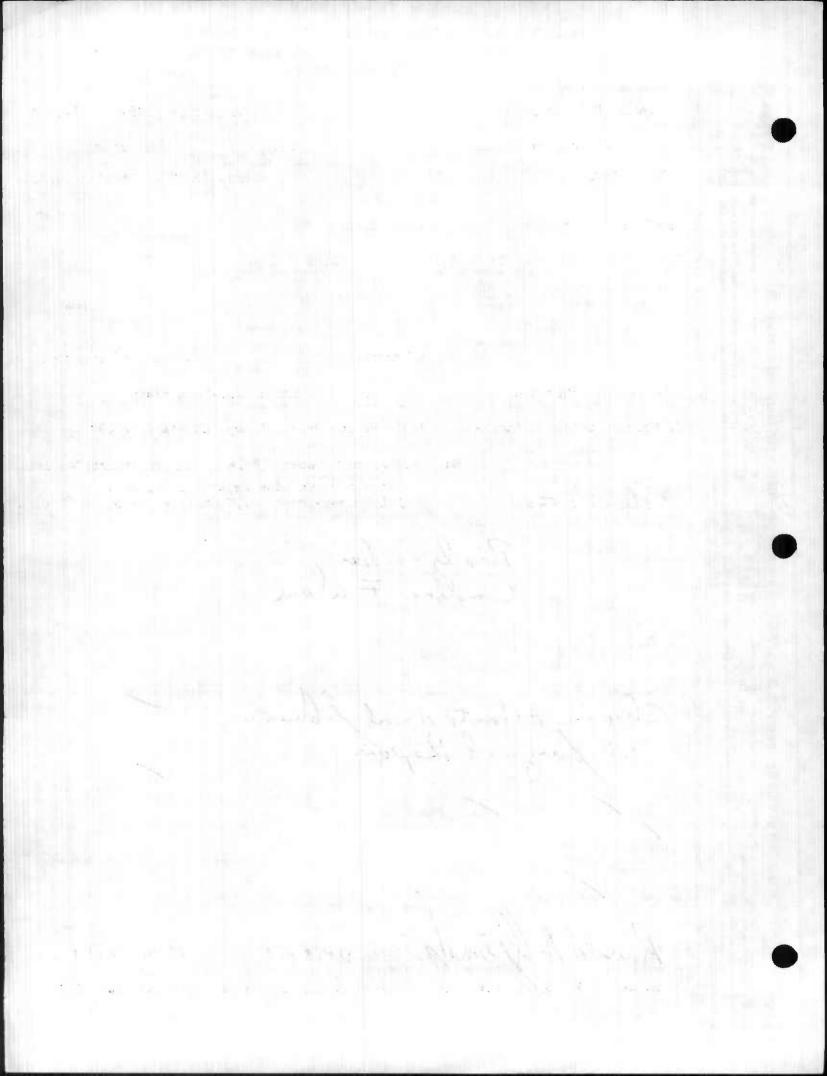
Ronald H. Uscinski. 18111 Prince Philip Drive#104 Olney, Maryland 20832 M.D.

State Registrar 31. Date filed (Month, Dey, Yeer) AUG 16 1999

32. Registrar's Signature

within 2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First Middle Last) 2. Data of Death 3. Time of Death **Physician** 2:00 P.m Alice Elizabeth Alejo Hughn 1) /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Anna Glen Arunde Arundel Hospita If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 25 F Months Yrs Director 87 577-16-5857 March 21,1912 Kansas Usual Residence of Deceden 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examine, must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 416 Westbury Drive 21140 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within and Mental Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) 12 Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) John William Brown Katie Newton 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar important: If item 27 is any injury or other trau Patricia A. Beall (daughter) 416 Westbury Drive 21140 Riva, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 8/16/99 Silver Spring, Maryland 21. Signature of Funeral Service Licens is 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final neu mong disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner certificate be executed and bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequenca of): physiclan Physician/Medical the Due to (or as a consequenca of): 63 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yes this cartificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient pletaly filled in by the funeral 27. Manger of Death Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours a

To the To the To the State

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29s. Certifier

Baltimore, F

Box 68760,

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Division of Vital

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and placa, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

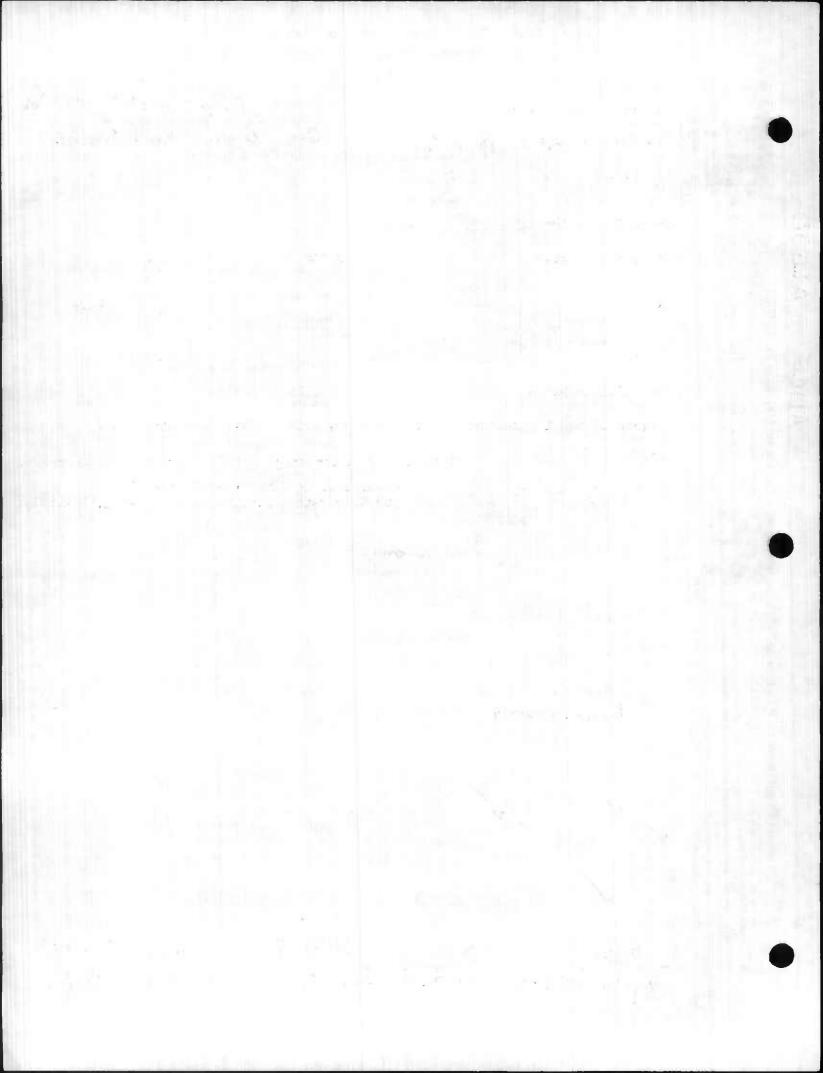
of purion who completed cause of deeth (Item 23e) (Type, Print) 30. Name and all

Bume.

31. Date filed (Month, Day, Year) AUG 16 1999

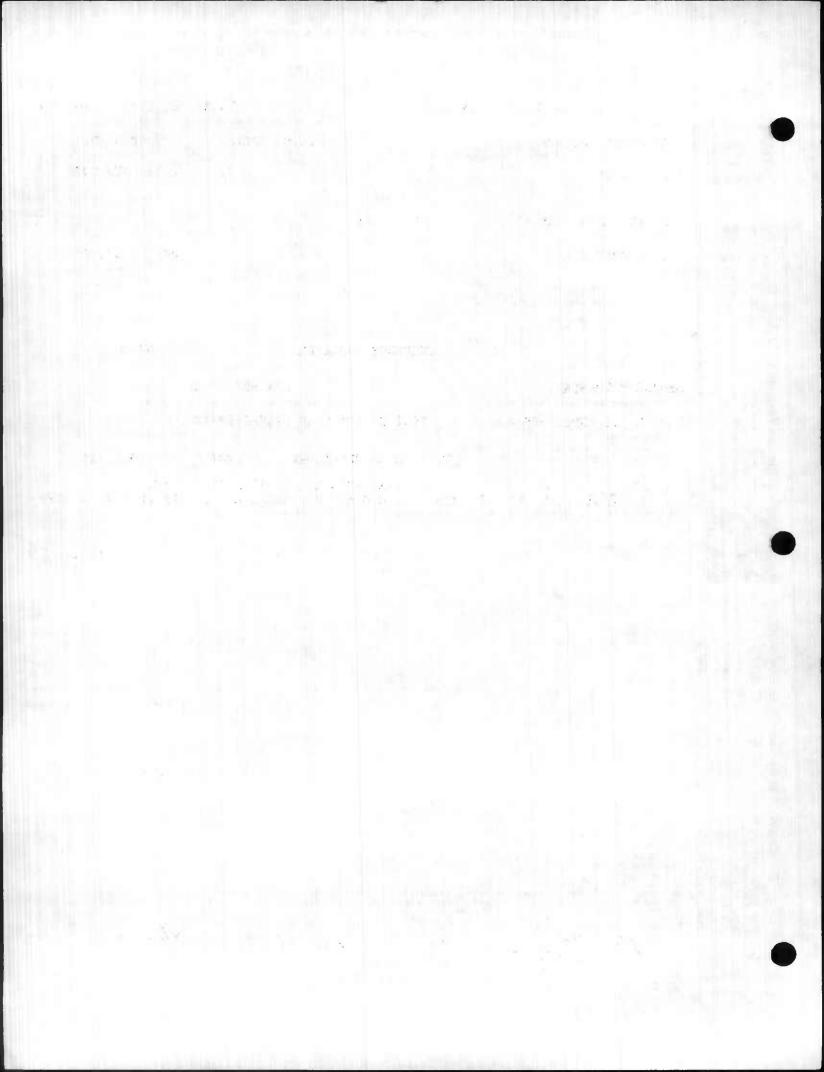
32. Registrar's Signature

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 2 7 | 4 6

							Cer	titical	e or	Death			Reg. N	No.		
Physi /Med		1. Decedent's Name	DEBORAH	JEAN	ALEX	ANDER						2. Date of D Month AUGUS'	D), 199	Year	3. Time of Death $10:47\text{PM}$
Exam		4a Fecility Name (II	0. 12 **		um <i>ber)</i>	-						cation of Dec		c. County	of Death	2011
Funera Directo	_	5. Social Security N 113-46-25	umber 6.3	AL Sex 1□M 2⊠F	7. Age (In yrs. last bii	thday) Yrs.	If Unde Months	r 1 Year	SILVEI If Under Hours	24 Hrs. Min.	RING 6. Dete of B (Month, D JAN 2	irth Day, Yea	ar)	9. Birth Cou NEW	CRY place (State or Foreign ntry) YORK
e Maryland Sa-f show	ector	Usuel Residence of 10a. State MARYLAND	10b. County MONTGOM	IERY	1	Oc. City, Tow		SPR								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	Dire	10e. Street and Nur 9901 SIDN						10f. Zij		0901				Citizen of V		
ATICL K. I.Z. I.DUUZU be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or flems 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status	ed 2 Married	12. Was De Armed F 1 Yes If Yes, G Year or	Forces? 20 No				dent of h		gin? (Spe n, Puerto	ecify Yes or N Ricen, etc.)		14. Rac	e - Americk, Whita, WH T	can Indian, etc.
Z I Z I D-UUZU within 72 hours af jiene. r than "natural", or me wed gal Exam	Completed	(Speci	15. Decedent's E ify only highest grandary (0-12)	ade completed Coilege	1) (1-4or 5+) 4		(Give I life. D	ent's Usu kind of wo OO NOT u	ork done se retire	during mos d)	t of worki	ing		Kind of Bu		dustry
Maryland 212 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be Co	17. Father's Name (T	001	исы	OI L	NOIUI	18. Mothe		(First, Middle	e, Maide			
		19a. Informant's Na SAMUEL AL 20a. Mathod of Disp	EXANDER/		D	99 20b. Place o	01 S	SIDNI sition (Na	EY R	OAD S		R SPRI	NG,		0901	
permit. Pages 1 and 2 Department of Health s Important: if tham 27 is		1 ☐ Burial 25 4 ☐ Donation	Cremation 3 5 Other (Special	fy)	n Stete	FT. LI	ny, cram	LN C	other pla REMA	TORY		8/20/9				
Deparing any ir		21. Signeture of Fu	than	l. D.	nez	0	HI 11	NES-1	RINA NEW	HAMPS	UNER.		ILVE		RING	MD 20904
Physiciar /Medica	_	23a. Part1. Enter the shock, or hear	Final										arrest,		1	Approximata Interval Between Onset and Death
Examine		disease or condition rasulting in death)	n	a. Me		ua to (or as a			251	Ca	7/10	9			1	11 years
certificate be axecuted nding physician and use as the burial-transit	n/Medical Examiner	Sequentially list cor if eny, leading to im ceusa. Entar Under Cause (Disaase or that initiated evants	mediate rlying Injury	C		ua to (or as a										
		resulting in death) L	ast	d		e to (or as a	consequ	dence or):							-	
ires that the death signed by the attend to deteched for its	Physicia	Part II. Other signifi	cant conditions of	contributing to	death but r	not resulting i	n the un	nderlying	ceuse giv	ven In Part I		23b. Did tobacco usa contribute to the cause of o				
w requirements	Completed by												tormed?		av cc of	ere autopsy findings veileble prior to ceileble prior to completion of cause deeth?
or Attending Physicism: The la after death. Director: After this certificate has i in by the funeral director, page 2	25. Was cese raferred to medical axaminer? 1 Yes 2 No									pleath (Check only one) ploma 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred				(y)		
To the Hospital or Attending Physicial Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:											281. Location City or T			er or Aur	al Routa Number,
To the Hospital or / within 24 hours after To the Funeral Direct completely filled in b	edicai	29a. Certifier (Check only one) 29a. Certifying Phyalcian: To the best of my knowladga, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.											o the cause(s)			
8 With the	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)														
		30. Name and addre	ess of person who	completed cell	usa of deal	th (Itam 23a) EOCGIA	HV AV	E.#	400	Silu	BC &	DRING	mi	0 20	910-	3605
S	tate	31. Date filed (Mont	h, Day, Year)		Registrar's	Signature	4	1	. 10	,						



					State of	of Mai	rylan					Health a		Mental H		ene To	27	14/
	Physicia /Medic	_	1. Decedent's Name (First, Midd Walter	le, Last)		ngs	t							2. Date of Month Augu		Day 13,	Van	7:35am
	Examin		4a Facility Name (If not institution Hebrew Home				Wa	shi	not	on		4b. City, To Rock		ocation of De	ath	4c. County	of Death	rv
	Funeral Director		5. Social Security Number 577 - 46 - 6268	6. Sex		7. Age		last birti	hday)		r 1 Year Days	If Under	24 Hre	8. Date of (Month) Oct, 1	Birth Day, Y		9. Birthplace	State or Foreign
h	•		Usual Residenca of Decedent 10a. State 10b. County				10c. Cit	y, Town	or Loca	ation					,		10d.	Inside City Limits
	th the Mar	Director	MD Mont	gom	ery		Si	lve	er S	of. Zip	ng Code				10g	J. Citizen of \	What Country?	Yes 2□No
	ath wi	rai	2602 Evans									0902				USA		
020	72 hours after death with the Maryland *netural", or frame 23a or 28a-f ahow ad cal Examinet must be notified at	by Funeral	11. Marital Status 1 Never Married XXMar 3 Widowed 4 Divorced	rled	12. Was Dec Armed For 1 Tyes If Yes, G Year or D	orces? 2 🔯 No ive		,S.				Hispanic Ori pan, Mexicar Specify:		pecify Yes or Rican, etc.)	No-		a - American I ck, White, etc.	
21215-0020	.S	Completed	15. Deceder (Specify only higher Elementery/Secondary (0-12)	it's Edu	cation e co <i>mpleted)</i> College ()					pation during mos					usiness/Indust	
Maryland 2	should be filed with and Mental Hygiena. Is marked other than aumatic avant, the	Be	1 2 17. Father's Name (First, Middle,					Se	enio	or (Cons		er's Nam	ne (First, Mide	die, Ma	iden Suman		vernmen
ryla	2 should and Men la marke	2	Walter Ang 19a, Informant's Name/Relations		na Print			10h	Mailing	Addros	e (Stead			beth			State, Zip Co	del
	and 2 sl ealth an n 27 le r		Kate Angst					1	-					ilver				20902
Baltimore,	of H		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5	3 □R	lemoval from	State				ition (Ne		orial	8	Date / 16/9			City or Town,	
Baltir	permit. Pag Department Important: fi any injury o		21. Signature of Europeal Service		9/3	7		g 1	22.	Name a	nd Addr	ess of Facili	ty Ta	koma	Fu	neral	Home DC 2	
	Physician		23a. Part . Enter the disease, o shock, or heart failure. Lis	compa	cations that ne cause on	caused in each line	ie deat	h. Don	ot enter	the mo	de of dy	ing, such es	cardiac	or respirator	y arres	it,	int	proximate ervai Between usef and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	8	CE					A ence of)		ERY	/	DIS	EA	ISE	>	EARS
	D #	iner			ATH							5					Y	EARS
,092	be axecuted siclan and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		b. ATHERD SCLEROSIS Due to (or as a consequence of):													
9	2 5 2	Physician/Medic	that initiated events resulting in death) Last	l	i	D	ue to (o	rasac	onsequ	enca of):								
. Box	atter for u	iciar	Part II. Other significant conditi	ons con	atributing to d	leath but	not res	ultina in	the unc	derlying	cause o	iven in Part	1	23b. D	id tob	acco use co	ntribute to the	e causs of death
s, P.O														1	☐ Yss	2 □ No	3 Probab	ly 4 ☐ Unknow
Record	law requiras that as been signed b 2 should be dete	Completed by	CHRONIC	110	_ /	50	HE	MI	A		24a. Was an autopsy performed?				availe	autopsy findings ble prior to etion of cause th?		
E B	The law ate has page 2	E CO												1	☐ Yes	2 No	1 □ Y	es 2 No
Vital		Be	25. Was case referred to medical examiner?		1						- 10		e of Dee	th (Check on	ly one)		
of	hy hy	2	1 ☐ Yes 2 1 No	-		Inpatient	2 🗆	ER/Out	-		UA		ursing H	ome 5□R	_			
Division o	anding P eath. or: After t	Certification:	27. Manner of Death 1. Natural 5 Pendii 2 Accident invest	be .					No			v Injury occur						
Divi	Hospital or Attanding 24 hours after death. Funeral Director: After taly filled in by the fune	Certifi	3 Sulcide 6 Could not be determined 28e. Plece of Injury - At building, etc. (Special Could not be determined building, etc. (Special Could not be determined building).					ome, far	rm, stre	et, factor	ry, office			28f. Locatio City or	n (Stre Town,	et and Numi State)	ber or Rural R	oute Number,
		edical			ner: On the b		xamina										enner as stete and due to the	
	To the	Z	29b. Signature and title of certifie	r	. /	2				29	c. Licen	se number			290	d. Date signe	d (Month, Day	r, Year)

State

Registrar

Steven Lipson 6
31. Date filed (Month, Day, Year)

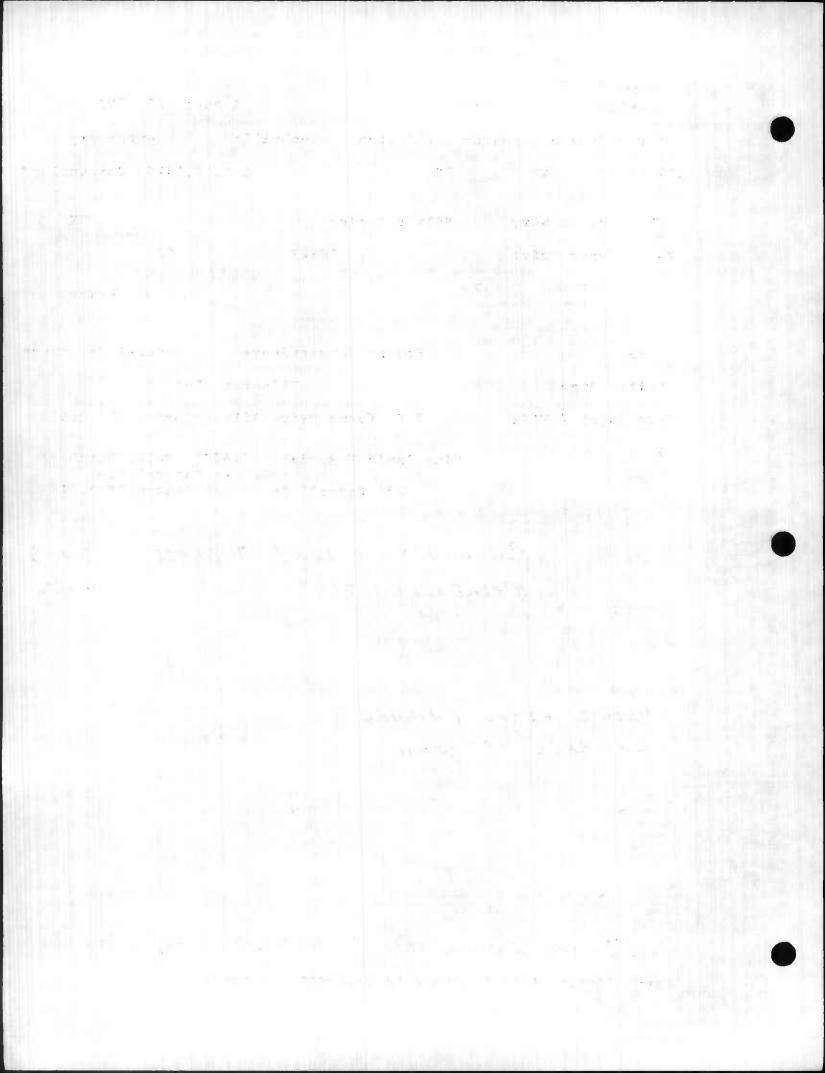
AUG 17 1999

30. Name and address of parson who completed cause of death (item 23a) (Type, Print)

6121 Montrose Rd Rockville MD 20852 G. Sparks

DHMH 16 Rav 6/95

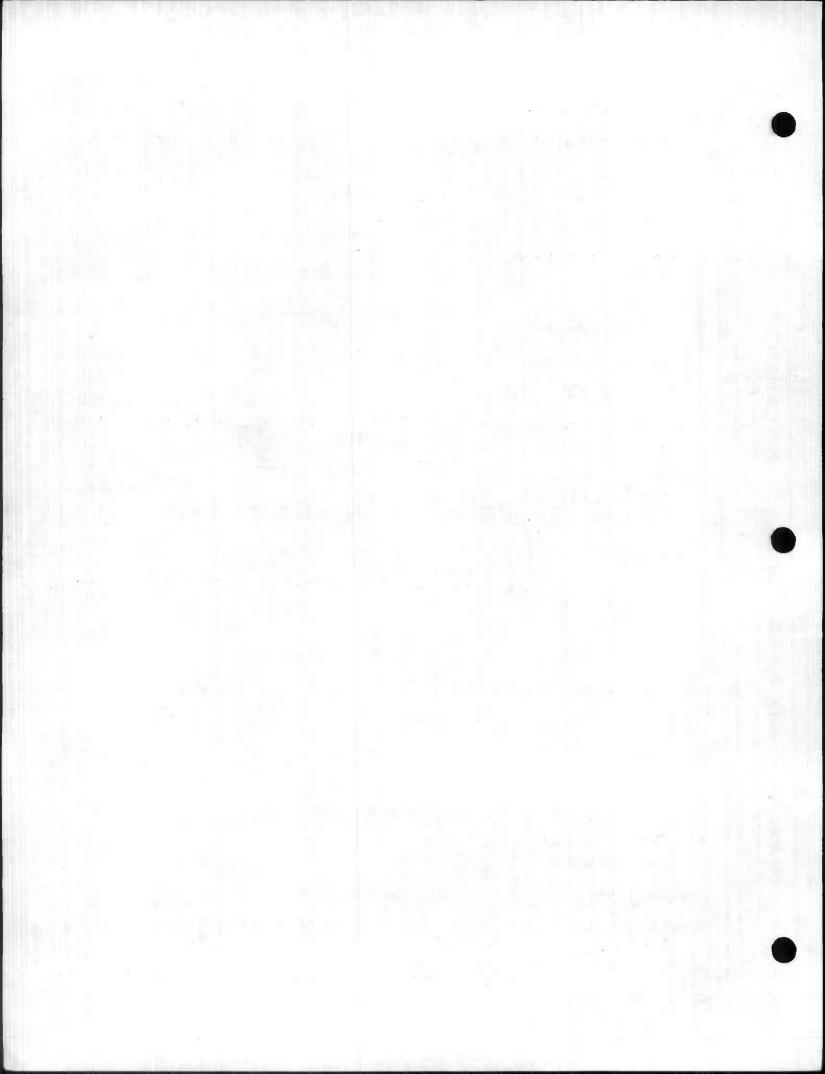
12



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 7 | 4 8

			Ce	rtificat	e of	Death			Reg. No.		
	1. Decedent's Name (First, Middla, Li	rst)						2. Data of De			3. Time of Death
Physician	Cristeta P. Aqu	iino						Month	Day	- go	3 NOON
/Medical	4a Facility Nama (If not institution, gir					4b. City, To	wn, or Lo	ocation of Deal	-	County of De	
Examiner					-						
	Holy Cross Hospit 5. Social Security Number 6.		rs. last birthday	If Under	1 Vear	511V		pring		lontgom	
Funeral Director		all all a	74 Yrs.	Months	Days	Hours	Min.	8. Data of Bi (Month, Di Oct. 29	ay, Year)	24 Ph	irthplace (State or Foreign Country) illipines
show show	10a. Stata 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits 1 ☐ Yes 2X No
or 28e4 s be notified	Maryland Montgon	nery	Germant								
or death with the Maryland liters 23e or 23e-f show ner must be notified at uneeral Director	10e. Street and Number 14300 Poplar Hill	Road		10f. Zip	Code 374				-	ed Sta	
des des	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S. 13.	Was Deced	dent of h	lispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	0-		nerican Indian,
	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yas 2 No If Yas, Giva Year or Datas:		1 Yas		Specify:		rican, etc.)		Black, Wh Specify:	ilapino
Maryland 21215-0020 62 should be fled within 72 hours at th and Mental Hygiene. 7 is marked other than "natural", or traumetic event, the Medical Exam To Be Completed by I	15. Decedant's E (Specify only highast gr		(Giva	edent's Usua a kind of wo DO NOT us	rk done	durina mos	st of work	ing	16b. Kii	nd of Busines	
12 mp selling	Elementary/Secondary (0-12)	College (1-4or 5+)				2)			D.,	111- 0	-b1-
C PART OO	17. Fathar's Nama (First, Middla, Lasi	4	T	eachei	r	40 Math	ada Mana	- Alliant Adiabate			Schools
Be ever)				18. Mothe	ers Name	e (First, Middle	, Maloen	Sumama)	
To stand	Braulio Palabay							Dume 1			
ABA 2 sh and is m	19e. Informant's Name/Reletionship	(Type, Print)	19b. Maili	ing Addrass	(Street	and Numb	er or Run	al Routa Numb	per, City or	r Town, State	, Zip Code)
N Dung	Nicanor F. Aquino	/Husband	1430	O Popi	lar	Hill	Road	, Germa	antow	m, MD	20874
of the table	20a. Mathod of Disposition		b. Place of Dispo	osition (Nan	na of	sal .		Deta	20c. Lo	cation - City o	or Town, Stata
Baltimore emit. Pages 1. Nepartment of Hu mportant: if then ny Injury or oth Kics.	1 Burial 2 Cramation 3 C		Cata a C	. II	iriar pro-	Aug	. 21	, 1999	C41.	con Con	of mo MD
# " # # # ·	21. Signature of Funeral Service Lice	1	Gate of					and A			ing, MD Funeral Home/
B	NouilE	1)	R	ockvi.	11e,	Inc.	30		Mont	gomery	Avenue
	23a. Part1. Enfer the disease, or conshock, or heart failura. List only	plications that caused the door one cause on each line.	eath. Do not en	ntar tha mod	a of dyir	ng, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical	Immediata Causa (Final	1.00/1800	0	חממ	ar	V2 1	ha	11_1			YEUDD
Examiner	disassa or condition resulting in deeth)	1 SCHEM!	CI	ARD(01.	1808	HUY	77			, CHIZI
je je	_	CORONA	o (or es e conse	equence of):	46	RO	W C	LER	001	S	YEAD
executed in and instransit	Sequentially list conditions, if any, laading to immediate cause. Entar Undarlying Cause (Disease or Injury	Dua to	o (or as a conse	quence of):							1
. Box 68760, death certificate be executed e attending physician and by for use as the burist-transit sician/Medical Examir	Cause (Disease or Injury that initiated evants rasulting in death) Last	cDua fo	o (or as a consec	quence of):							
× 5 50 2		d									
P.O. BO) at the death ce d by the attend etached for us, Physician/	Part II. Other algnificant conditions	and the time to death but not	resulting in the .		sussisk	on in Dort I		22h Did	tohanan		to the one on and death?
	Part II. Other alignmeant conditions (contributing to death but not	rasulang in tha t	underlying c	ausa gr	en in Parti					te to the cause of death?
by bed								10	Yas 2	□ (10 3□	Probably 4 Unknown
C) > 10 0 .I									s an autop ormed?	sy 24t	Ware autopsy findings available prior to completion of cause of death?
I Re lev The lev page 2								10	Yes 28	≥No	1 ☐ Yes 2 ☐ No
Vital Sician: Tr certificate irector, pa	25. Was case refarred to medical				-	OC Place	1 D1			-1.5	
Vita	axaminar?	Hospitel:			Oth	ar		h (Check only		-	
F Side F	1 Yas Salve	1 Hopatient 2	ER/Outpatie		^^	4 LI N	-	ma 5 Ras			pecify)
After funer funer	1 €Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Tima o Injury		Bc. Injui Woi			28d. Dascribe	now injur	y occurred	
Attending or death. ector: After by the fune tiffication	2 Accident invastigatio			М	1 📙	Yes 2	No				
Division of the or attending P is after death. In Director: After the in by the funers Certification:	3 Suicide 6 Could not be detarmined	28a. Pleca of Injury - A building, etc. (Spe	t homa, ferm, st ecify)	reet, factory	, office				(Street and wn, State)		Rural Route Number,
Hospi 24 hou Funer Hely fill		nysicien: To the best of my lander: On the basis of axam and mannar stated.									
To the within To the comple	29b. Signatura and titla of certifier	AL		290	. Licens	e number			29d. Dat	aysigned (Mo	rith, Day, Year)
	1 Omuel	£ 960	2	0	0	55	68		DA	156	77
Q	30. Name and address of person who	completed causa of death (tem 23a (Type,	Print)	1	Vek	: 5	PRIN	2	MD	20902
State Registrar	31. Dafe filed (Month, Day, Year)	32. Registrar's Signature	gnature -	1		,					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 6:45 Pm Angust
4b. City, Town, or Location of Deeth Hedi Axelrad /Medical 4e. Fecility Neme (If not institution, give street end number) **Examiner** Doctor's Community Hospital Prince Georges

9. Birthplece (State or Foreign Country) Lanham If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Months 111-22-4845 Director Jan 30, 1907 Austria Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rsi', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Middlesex Highland Park 10e. Street and Number 10g. Citizen of What Country? 909 South Park Ave Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 08904 by Funeral USA 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Biack, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced Completed permit. Peges 1 and 2 should be filed within 72 h. Department of Health end Mental Hygiene. Important: If item 27 is merked other than "naturany injury or other traumatic event, the Medical page. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Secretary/Bookkeeper Fiber Chemical Co 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Adolph Traub Celia Krauz 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 121 Northway RD. Greenbelt, MD 20770 Ava Chopra/ Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 \(\frac{1}{2} \) Cremetion 3 \(\) Removal from State 4 \(\) Donetion 5 \(\) Other (Specify) Beth Israel Cemetery 8/16/99 Woodbridge NJ 22. Neme end Address of Fecility Takoma Funeral Home 254 Carroll St Nw Washington DC 20012 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, abock, or heart feilure. List only one ceuse on each line. **Physician** /Medicai Immediate Cause (Final Gastro intestinal Bleeding disease or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of). Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cougos tive Heart Failure Mitral and acostic Valve Disease 24e. Wes an eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? Colonic augiodysphsia 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was cese referred to medical exeminer? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number lavil Sean to MD D17572 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

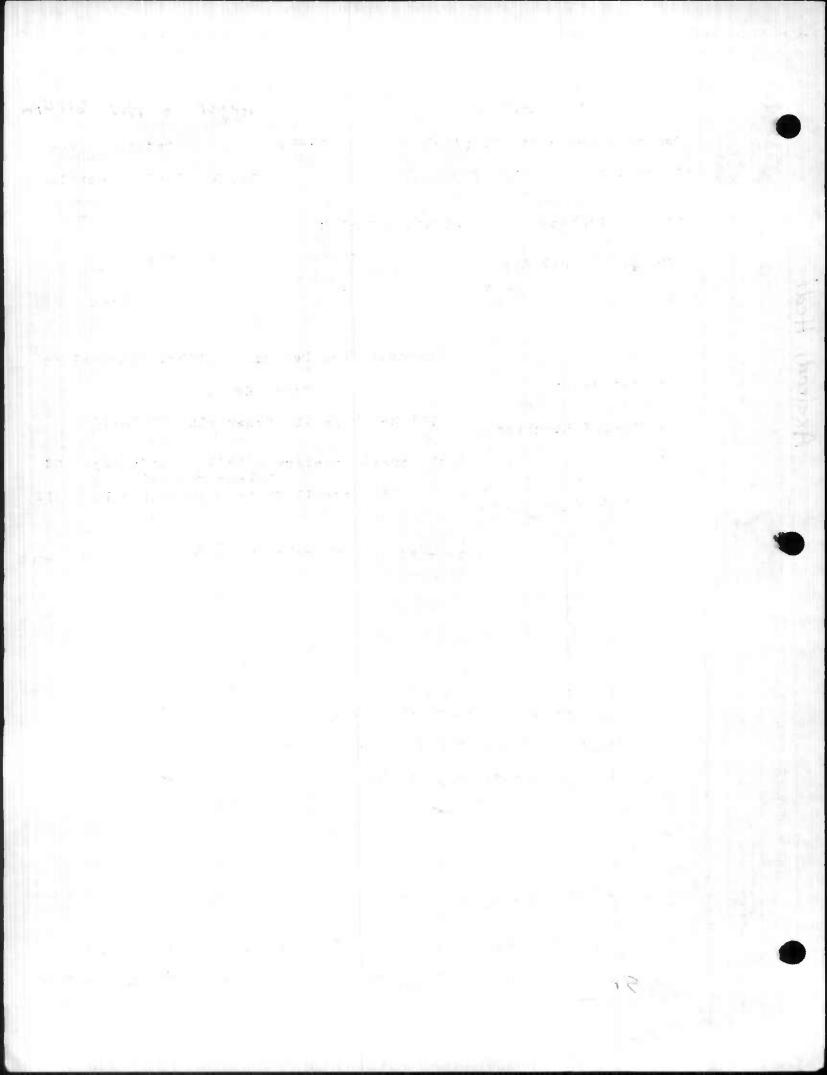
D. Grante MD 115 (ess He 115 Centerway greenbelt, 120 20770 31. Date filed (Month, Day, Year) AUG 1 7 1999 32. Registrar's Signeture State Registrar

P.O. Box 68760,

Records,

of Vital

Division



State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BEBBER 1616 DEETTE 8 10 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number 4c. County of Deeth Examiner Havre de Grace Harford Harford Memorial Hospital If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country)
 N C 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 200 F Months Days Hours Min Yrs. Director 66 03/27/1933 239-44-3010 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f ahow any Injury or other traumatic event, the Medical Examination and pages. 10a, Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Cecil Perryville MD 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? USA 21903 Funeral 101 C Carter Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10th Machine Operator Factory 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Myrtle Elizabeth Blevins Ambrose Click Waddell 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 16 Lapidum Road, Havre de Grace, MD 21078 Debra B. Smith- Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 M Burial 2 Cremetion 3 DRemovel from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 8/13/99 Bel Air, MD 21. Slaneture of Funerel Service Licenses 22. Neme end Address of Fecility Mitchell-Smith Funeral Home, P.A. 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. MD 21078 Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the daeth cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the a 23b. Dld tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to 24a. Wes an autopsy performed? Completed completion of cause of deeth? irector, pega 2 s almora 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Affar 1 Divatural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) No Funeral Directory of the Puneral Directory of the Puneral Directory of the Puneral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical completaly (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) end menner stated. To the Vithin 2 290. Signatury and little of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) S. UNION AVE. Havre de Gace Mel. S.GALVEZ LETIELA 625 M.D. 32. Pagistrar's Signature State Registrar

Mrs 1 1 1886 pr -- 19 1/2 9/14

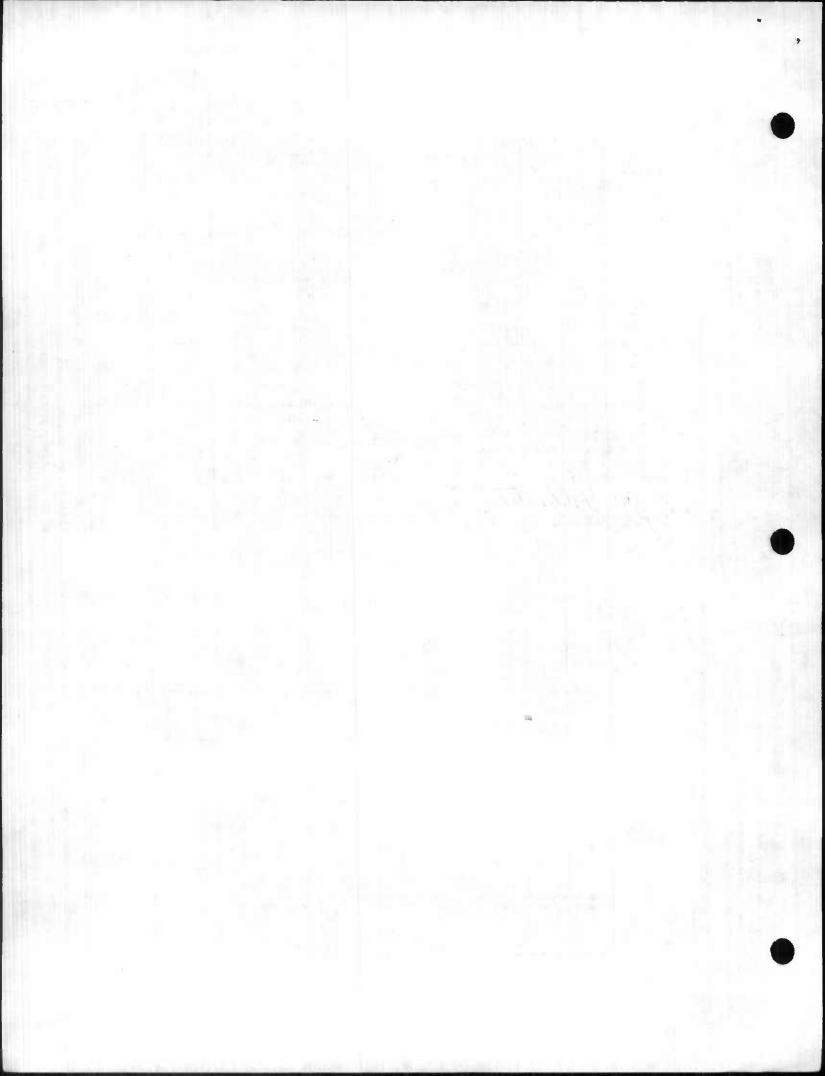
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month **Physician** JULIE BISHOP 1999 AUGUST 1:30 P.M. 11, /Medical 4s Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7505 BRADLEY BOULEVARD BETHESDA MONTGOMERY 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUGUST 16, 1909 FLORIDA **Funeral** Months 1□M 2\ F Days Hours 89 261-52-8426 Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits Wes 2 No Director 28a-f LEON TALLAHASEE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 3526 CASTLEBAR CIRCLE 32308 UNITED STATES Funeral therma: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. 14. Rece - Amarican Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: Black, Whita, atc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. þ 3XIWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) MUSIC TEACHER EDUCATION 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ments! He was 1 and Ments! He want: If hem 27 is marked objury or other traumatic even Be J. R. ZETROUER HATTIE DuBOSE 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAWN M. WHITENER/DAUGHTER 7505 BRADLEY BLVD. BETHESDA, MARYLAND 20817 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete XXBurial 2 Cremetion 3 Removel from State permit. Page Department of Important: If any injury or 8/15/99 LAKE MARY, FLORIDA 4 Donetion 5 Other (Specify) OAKLAWN PARK 22. Name end Address of Facility of Funeral Se HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 Inter the disease, or complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart tellure. List only one cause on each line. Approximata Interval Batwaan Onset and Deeth **Physician** /Medical Immediate Causa (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or as a consequence of). sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Last Due to (or es a consequence of): physician the burial P.O. Box 68760. Physician/Medicai Due to (or es a consequence of): 80 signed by the at the detached for Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 40 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 : has 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attanding Physician: funeral director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 No Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, term, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2D Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only ş 29b. Signatura and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2 DIVE D 15236 AUGUST 12,1999 10 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) CARL I. MARGOLIS, M.D. (OME) 11125 ROCKVILLE PIKE #211 ROCKVILLE, MD 20852 31. Date filed Worth, Day Year) 1999 32 Registrar's Signature State

Registrar **DHMH 16 Rev 6/95**

Division of Vital



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Physician /Medical		В.	Bogie		Aug 13	3, 1999 gar
Examiner	4e Fecility Name (If not institu		The state of the s	4b. City, Town, or Le		4c. County of Death
	Sacred Hear	t Hosp		Cumberla	ina	All
- maral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday) If Under 1 Y	ear If Under 24 Hrs.	8. Dete of Birth	9. Birth

Director

with the Maryland

item 27 is marked other than "naturel", or frems 23s or 28s-f show other traumetic event, the Modical Examiner must be notified at Directo Funeral þ Completed Be

namit. Peges 1 and 2 should be filed within 72 hours effer death Department of Health and Mental Hygiene. 9

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

2

Certification:

edical

29a. Certifier

(Check only one)

29b. Signature and title of cartille

physician and the bunal-transit 80 use been signed by the s should be detached page 2 s certificate director this funeral After

P.O. Box 68760,

Division of Vital Records,

requires that the deeth certificate be executed Hospital or Attending Physician: 24 hours after death.

Funeral Director: A filled in by completely To the within 2 To the

 Birthplace (State or Foreign Country) Months Deys Jun 17, Year) 1919 1 M 2 F 214-07-2345 80 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Allegany MD Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Honeysuckle Lane Apt. 324 21532 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes No Specify: Specify: white Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) former employee Textile 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Arthur D. Boyce Minnie L Harris 19a. Informant's Name/Relationship (Type, Print)
Royce & Lourn Boyce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14101 Winchester Rd; Cresaptown, MD 21502 nephew/brother
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 8/16/ Cumberland, MD 21. Signature of Fugeral Service Licenses 25 Carpers Fruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final 30 minutes disease or condition resulting in death) Acute Pulmonary Edema Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Congestive Heart Failure

Idiopathic Hypertrophic Subaortic Stenosis

Chronic Pulmonary Disease 25. Was cese referred to medical

examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28c. Injury at Work? **fnjury** 1 Tyes 2 No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number. City or Town, State)

26. Piace of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Aug 16, 1999

24a. Was an autopsy

1 Yes

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes 2 No

3. Time of Death

06:17am

Allegany

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

10701 New George's Creek SW Sui Frostburg MD Saturnina T. Chang M.D.

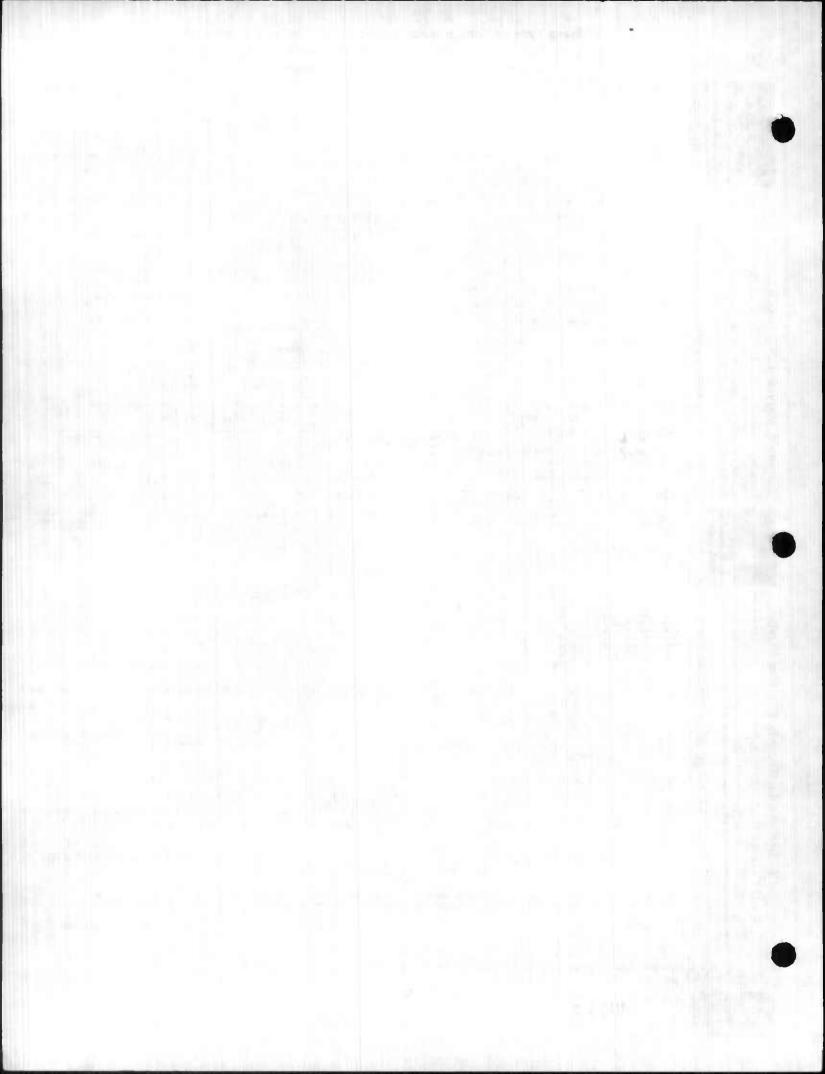
State Registrar 31. Date filed (Month, Day, Year) AUG 1 7 1999

32. Registrar's Signature ancina

Loon Kel

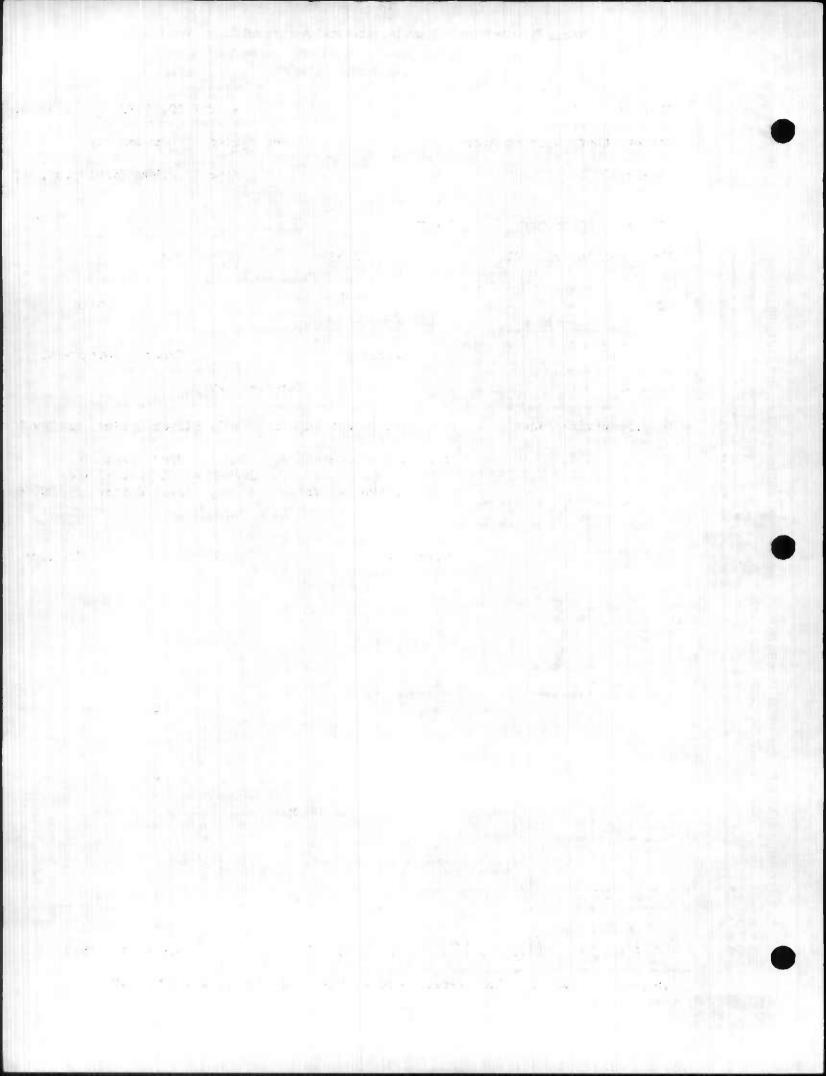
29c. License number

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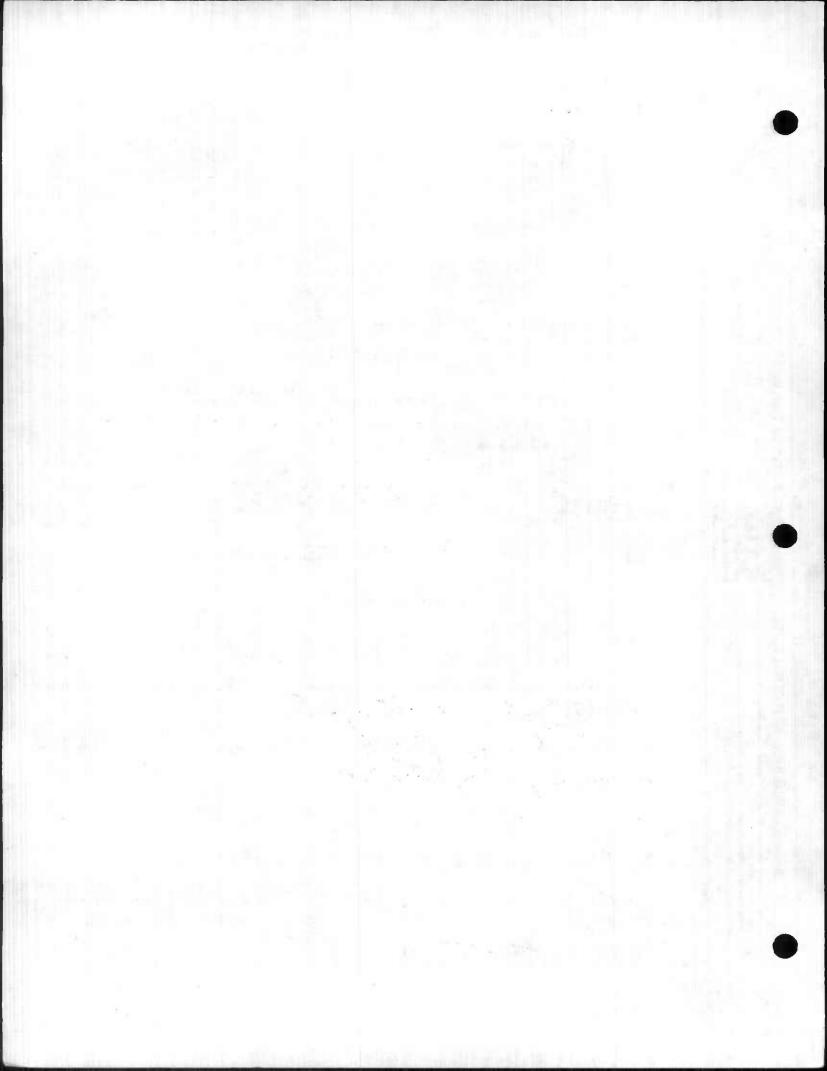
State of Maryland / Department of Health and Mental Hygiene

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Physician • /Medical	ELLEN F. BATES						AUGUST		
	4a Facility Nama (If not Institution, giva	street and number)				4b. City, Town, or	Location of Death		
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3a or 3	17811 Buehler Rd,	#81			10f. Zip Coda 2083	2		10g. Citizen of Wh USA	nat Country?
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowad 4 Divorcad	12. Was Dacedant I Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Datas:			Vas Dacedant of Yas, specify Cu □ Yas 2 1 N	Hispanic Origin? (Siban, Maxican, Puan o Specify:	specify Yas or No- to Rican, atc.)	14. Raca Black, Specify:	- Amarican Indian, , Whita, atc. White
Po P	15. Decedant's Edu	cation		16a. Deced	iant's Usual Occ	upation		16b. Kind of Busi	
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Irylan should be d Mental marked o matic eve	Amos A. Roper					Margar	et Dewey		
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Te, Mar 1 and 2 sh Health and em 27 is m wher traum	Dorothea Grimes/N	iece		3511	Forest	Edge Dr.	#2-D. S	ilver Sp	ring, MD 20906
Baltimore, pemir. Pages 1 an Department of Heal Important: If item 2 any injury or other page.	20a. Mathod of Disposition Y☐ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cer	aca of Dispo	sition (Nama of natory or other p coln Cer	laca)	Data Aug 13		City or Town, Stata
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Deparition of the parties of the par	1 alant Th	Danne 9	0	11	800 New	Hampshir	e Ave, S	ilver Sp	ring, MD 20904
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. Hist drily or Immediate Causa (Final disease or condition resulting in death)	na causa on aach Ili	Pneu	ımonia as a conseq					Approximate Interval Batween Onset and Death
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58760, cate be executed physician and stability and stability and stability and examility adical Examilia	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Dua to (or a	as a consaq	darica or).				
2 0 0	that initiated evants rasulting in death) Last		Dua to (or a	as a conseq	uance of):				
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P.O. BOX hat the death cert by the attending detached for use Physician/M	Part tt. Other significant conditions con	eributing to death bi	it not rasur	ting in tha u	idanying causa	givan in Part I.			3 Probably 4 Unknown
VItal Records, P.O. Box vician: The law requires that the death cer cardificate has been signed by the attendin irector, page 2 should be detached for use De Completed by Physician/N								an autopsy med?	24b. Wara autopsy findings available prior to complation of causa of death?
The law atta has page 2							101	as 2 No	1 ☐ Yas 2 ☐ No
vital infection: The cardificate rector, pag	25. Was casa rafarred to madical					26. Piaca of Da	ath (Chack only o	na)	
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State of Maryland / Department of Health and Mental Hygiene 99 27 154

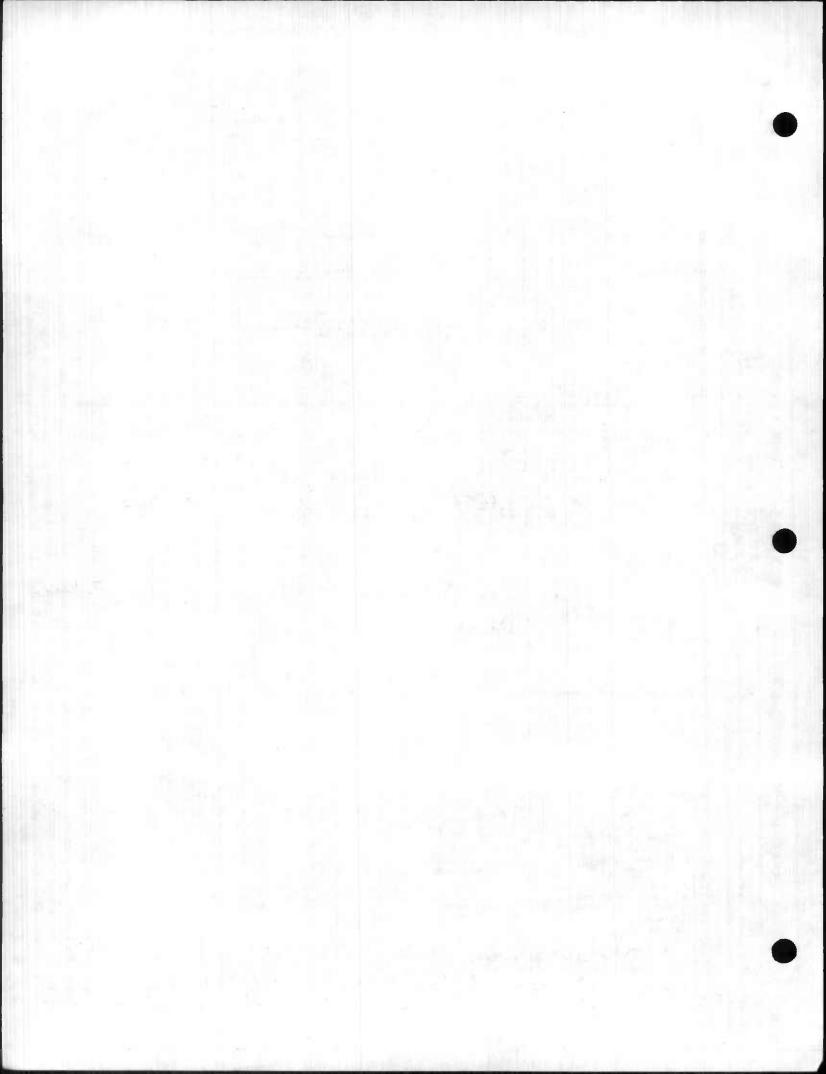
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	🗆 🗷	1. Decedent's Name (First, Middle, Las	st)				2. Data of Death		3. Time of Death
	Physician /Medical	Ariel L. Blisset	t				Month August 1	Dey Yeer 6 1999	9:50 PM
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		Mariner Health	of Bethesda			Rethesd	a	Montgome	rv
F	uneral	5. Social Security Number 6. S	ex 7. Age (h	n yrs. last birth	Months Day			Year) 9. Bit	nthplece (State or Foreign country)
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ylan	How	10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
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£	or 28	10e. Street and Number			10f. Zip Code		10	g. Citizen of Whet C	ountry?
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90	or flame 23s or 28e-flahov iminer must be notified at 7 Funeral Director	11. Marital Status	12. Wes Decedent Eve Armed Forces?	r in U,S.	13. Wes Decedent of If Yes, specify Co	f Hispanic Origin? (uban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Bleck, Whi	
21215-0020 d within 72 hours after death with the Manyland		1 ☐ Never Merried 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:		1□ Yes 2☑N	lo Specity:		Specify:	Black
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Maryland 2	2 2	17. Father's Name (First, Middle, Last)				18. Mother's N	eme (First, Middle, M	siden Sumame)	
arylan	o C	Charles Nelson				Henri	etta Nel	son	
2 sh	E E	19a. Informant's Name/Reletionship (7	'ype, Print)	19b. I	Mailing Address (Stre	et and Number or I	Rural Route Number,	City or Town, Stete,	Zip Code)
2 pue	27	Pearl L. Black	(daughter)	142	03 Greens	oan Lane		e,Marylan	
mit. Pages 1 to	9 8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐		20b. Plece of Cometery,	Disposition (Name of crematory or other p	elace)	Dete 20	Oc. Location - City or	r Town, Slete
E Bag	ury e	4 Donation 5 Other (Specify		Gate o	f Heaven C	Cemeterv	8/21/99 S	ilver Spr	ing Maryland
Balt Pemit.	Important: If item 27 any injury or other it ages.	21. Signalettijof Funeral Service Licen	500		22. Name end Add	fress of Fecility			
m 38	ESB	Xtern 1 St	in d				Funeral H		
		23a. Part1. Enter the disease, or comp shock, or heart tailure. List only	lications that caused the	death. Do no	t enter the mode of d	lying, such es cardi	ac or respiratory erres	et Spring	Approximeta Intervei Between
Phy	sician	shook, or real tailore. List only t	one cause on each line.	,	0				Onset and Deeth
	ledical	immediate Cause (Finel disease or condition	CONO	bron	Ma cula	n ar	ruden		
Exa	aminer	resulting in death)	B. Due	to (or as e co	risequence of):	1 10	2007-000	7	
77				•					
ords, P.O. Box 68760, requires that the death certificate be executed	ng physician and as the burlat-transit	Sequentially list conditions,	b. Due	to (or as e co	nsequence of):				
0	S S S	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury							
68760,	physicians the burners of ical	that initiated events resulting in death) Last	C. Due	to (or es a co	nsequence of):				
X e		, The Section 1, 1992, 1992,							
Box	for use		d						
0 8	stached for use Physician/	Part It. Other significant conditions co	ontributing to death but n	ot resulting in t	he underlying cause	given in Pert I	23b. Dld tob	acco una contribut	ta to the cause of death?
P. #	Phy Phy	anteresele	erosia.	mi	ltient	and	1 Type	2 No 3 F	Probably 42 Unknown
0 :	igned by the a be detached to by Physic	,	-	1	CNIJ.	(
Records,	page 2 should Completed	demente	1. 21	erish	erall ,	JANGAO!	24a. Wes en performe		. Were autopsy findings available prior to
0 3	9 CI D.	, , , , , ,	/ 0	1		00000	ve		completion of cause of death?
C =	Page Page	chren o	hu	serite	man		1 ☐ Yes	2 2 No	1 ☐ Yes 2 ☐ No
Vital	ertiflo.	25. Was case referred to medical axaminer?	/ //	1	7.3 50 7	26. Place of D	eeth (Check only one)	
Physic	T of	1 Yes 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Outp	atient 3 DOA	Other: Nursing	Home 5 Residen	ice 6 Other (Spi	ecity)
0 5	nera DD:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Ye	28b. Tir		jury al York?	28d. Describe hov	v injury occurred	
Vision Attending	Par Sa	2 Accident investigation				☐ Yes 2 ☐ No			
Division or Attending	al Director: After to in by the funeral Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Piece of Injury building, etc. (5	At home, fam Specify)	n, street, fectory, offic	×8	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
pltal		29a. Certifier 1 Certifying Phy	rsician: To the best of m	v knowledne i	leath occurred at the	time data and plac	on and due to the one	seale) and manner a	ac etatod
Hoe Hoe	To the Funeral Director: After this centificate ha completely filled in by the funeral director, page Medical Certification: To Be Com-		iner: On the basis of exa	minetion and/	or investigation, in my	y opinion, death oc	curred at the time, det	e and plece, and du	e to the cause(s)
To the	To the	29b. Signature and title of certifier	ar -	-	29c. Lice	nse number	29	d. Date signed (Mon	ith, Pey, Year)
5		> Ulling D	Logille	W M	n Di	7358	/////	18/18	199
0	~	30. Name and address of person who c	ompleted cause of death	(Item 23a) (T	ype, Print)	77 1	1	010	1
		Elliot R. Goldste				renue C	hevy Chase	Maruland	20815
1000	State	31. Date filed (Month, Day, Year)	32. Registrer's		econstii W	chue (nevy chase	, mary rand	20013
	Registrar	AUG 2.0 1000	Auren	v li		1 .			



State of Maryland / Department of Health and Mental Hygiene 9 27 | 55

			Certificate	e of Death	Re	g. No.	. 1100					
	T	1. Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Tima of Death					
Į,	Physiciar /Medica	Dity (Aphrodite) Bower			Month August	Day Year 16, 1999	8:45 AM					
	Examine	4a Facility Name (If not institution, give street and number)		4b. City, Town, or L	The state of the s	4c. County of Deat						
d		Holy Cross Hospital		Silver Sp	rino	Mont	gomery					
_	Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) If Under	1 Year If Under 24 Hrs.	8 Date of Birth		thplace (State or Foreign puntry)					
	Director	578-36-5687 1□ M 2気F 6	9 Yrs. Months	Days Hours Min.	(Month, Day, Nov. 18,		nington, D.C.					
	Aland Mand	10a. State 10b. County 10	c. City, Town or Location				10d. Inside City Limits					
	Man	Maryland Montgomery	Kensington				1 ☐ Yes 2 ☐ No					
	with the Marylan a or 28a-f ahow be notified at	10e. Street and Number	10i. Zip	Code	10	g. Citizen of What Co	ountry?					
	With With	10/21 Nouth Variation Davis		20895		IIO A						
	forms 23s	10431 North Kensington Parkwa 11. Marital Status 12. Wes Decedent Ever		ent of Hispanic Origin? (Spirity Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Ame	orican Indian,					
21215-0020	9 9 .	Armed Forces? 1 □ Never Married 2 □ Merned 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		ify Cuban, Mexican, Puerti D No Specify:	Rican, etc.)	Bleck, White	o, etc. Vhite					
ŏ	netural netural	15. Decedent's Education	16a, Decedent's Usua	/ Occupation	11	6b. Kind of Businass/						
15	C .	(Specify only highest grade completed)	(Give kind of wor	k done during most of work e retired)	king		,					
2	within tene.	Elementary/Secondary (0-12) College (1-4or 5+)	Waitress		1	Food Servi	Ce					
D	EISE A	17. Father's Name (First, Middle, Last)	Walted	18. Mother's Nam	e (First, Middle, M							
Maryland	Mental H Mental H arked off	Gus P. Chakalakis		Athen	a Ponties							
5	and Men marke	19a. Informent's Neme/Relationship (Type, Print)	19b. Meiling Address	(Street and Number or Ru			Zip Code)					
<u> </u>	d the											
e,	Health Hem 27 other tr	Harry Reed (son) 20a. Method of Disposition 2	19420 Rena Ob. Place of Disposition (Name	ne of		Maryland Oc. Location - City or						
Ö	90-2	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State	cemetery, crematory or or	ther place)								
Saitimore	tant fury		Gate of Heaver		3/19/99 8	ilver Spr	ing,Maryland					
Sai	permit. Pag Department Important: i eny injury o ptice.	21. Signeture of Funeral Service Ligarisee		d Address of Facility J. Collins	Funeral F	Home, Inc.						
	707 0	Tru S. Scerles		iversity Blv								
5	Physician	23a. Part f. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line.	death. Do not enter the mode	of dying, such as cardiac	or respiratory arre	st,	Approximete Interval Between Onset and Deeth					
1	/Medical	Immediate Cause (Finel disease or condition	Deic				3 days					
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	sician and burle-transit	Sequentially list conditions	to (or es a consequence of):	1001			Song -					
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5	uires that the death cer signed by the attendir id be detached for use	Pert II. Other significant conditions contributing to death but no	t resulting in the underlying ca	iuse given in Pert I.			n to the cause of death?					
	that ded b				1 Ye	8 2 No 3 P	robably 48 Unknown					
Records,	requires that seen signed be detected by Diggs				24a. Wes er	autonsy 24b.	Were autopsy tindings					
ò	per				perform	ed?	available prior to completion of cause					
ě	has b						of death?					
=	The la				1 □ Ye	s 2 No	1 ☐ Yes 2 No					
Vital	Physicien: The Christon and director, pag. To Re Co.	25. Was case referred to medical examiner?			th (Check only one)						
0	this cal dire		2 ER/Outpatient 3 DO		ome 5 Reside	nce 6 Other (Spe	icity)					
	Ter the real factor of the real	27. Manner of Death 1. Natural 5 □ Pending (Month, Day Yell) 1. Natural 5 □ Pending	28b. Time of 2 Injury 2	Bc. Injury at Work?	28d. Describe ho	w injury occurred						
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Division	tal or Attending P is after death. al Director: After to in by the funeral Court (Court (Cou	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S)	At home, farm, sireet, factory	, office	28f. Location (Str. City or Town	eet and Number or R State)	ural Route Number,					
٥	and	building, old. [O	occnyy									
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Madical Cartiff	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.										
	within To the compl	29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	P S P O	Colon and all and	11 >	NE220	1	28/17	100					
	15	9007 MC DO M.D. DO 238 08/11/99										
	1-	30. Name and address of person who completed cause of death	(Item 23a) (Type, Print)	alou Da	Sil	or on.	I IIA MOG					
		31. Date filed (Month, Day, Year) 22. Registrar's S	Simpoture	vacce Kg	37170	July July	1 140 2011					
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State of Maryland / Department of Health and Mental Hygiene

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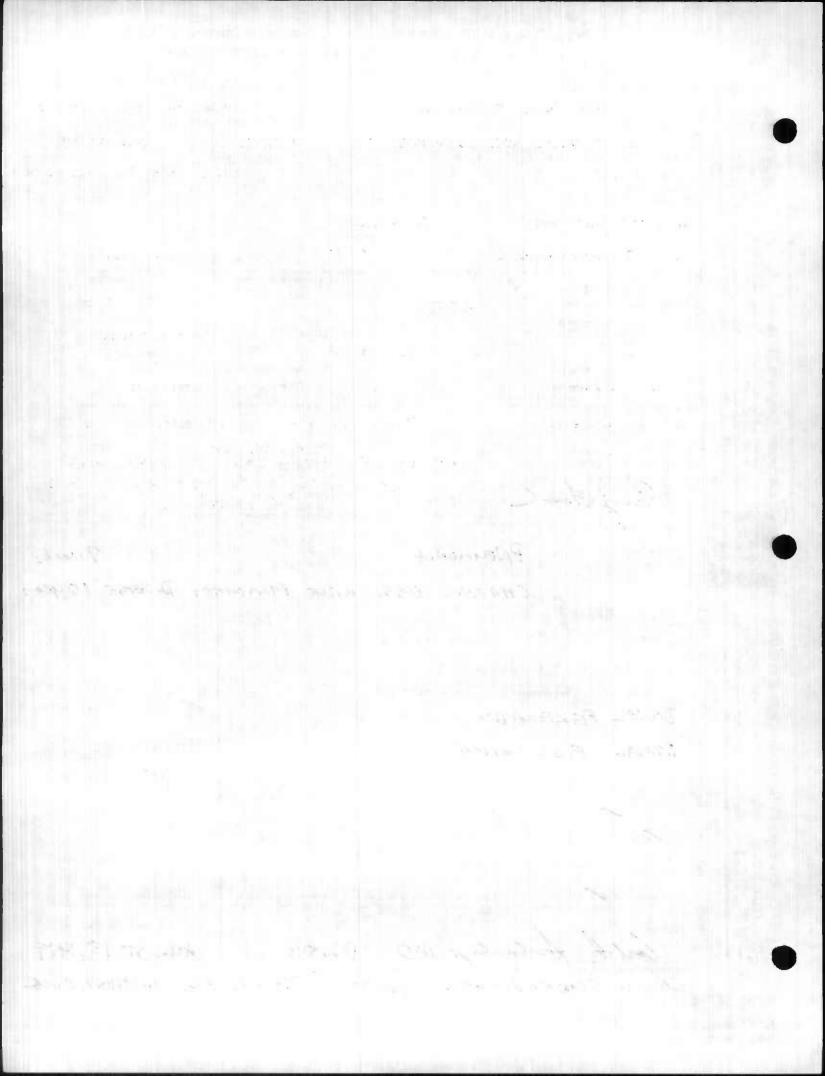
						ertificate				Reg. No.			
	1. Decedent's Nen	ne (First, Middle, L	.ast)						2. Dete of De		Vaar	3. Time of Deet	h
Physician		Robert J	oseph B	owers,	Sr.				Augus	t 18, 19	Year 999	1:00 P	M
/Medical Examiner	4a Facility Neme	(If not institution, g	ive street end nu	ımber)		_	4	b. City, Town, or	Location of Deal				
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Funeral	5. Sociel Security I		Sex		s. lest birthde	y) If Under 1	1 Year	If Under 24 Hrs	8. Dete of Bi			place (Stete or Fore	вig
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by l	11. Meritel Stetus 1 Never Mer 3 Widowed	rled 2⊠ Merried 4 □ Divorced	Armed For 1 (X) Yes It Yes, G	2 No		it Yes, speci		spenic Origin? (: in, Mexican, Puel Specity:	Specify Yes or Ne to Rican, etc.)	Bie Specil	ck, White,		
a p		15. Decedent's	Education		16e. Dec	cedent's Usuel	l Occupa	ation		16b. Kind of B	usiness/In	dustry	
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omp	Elementary/Sec	ondary (0-12)	College ((1-401 3+)	E1e	ectrici	ian			Conti	racto	r	
Be C	17. Father's Name	(First, Middle, Las	st)				T	18. Mother's Ne	me (First, Middle	, Maiden Sumer	ne)		
To B	Clyde H	P. Bowers						Carme:	La C. To	rregross	sa		
E S	19e. Intorment's N	lame/Reletionship	(Type, Print)		19b. Ma	iling Address	(Street	end Number or F	ural Route Numb	ber, City or Town	, Stete, Zip	Code)	
14.0	Mary P.	Bowers/W	ife		1951	5 Fred	leri	ck RdL	ot 1, Ge	ermantow	m. MT	20876	
otho	20e. Method of Dis			20b	Diagn of Diag	position /Alam	10.00		Date	20c. Location			
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Important: If any injury or once.	4 Donetion 5 Other (Specity) Montgomery Crematorium, Inc. Bethesda, 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/Rock 300 West Montgomery Avenue Rockville, Maryland 20850-2805												
importan any injur once.													c.
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State Registrar 31. Date tiled (Month, Dey, Year)

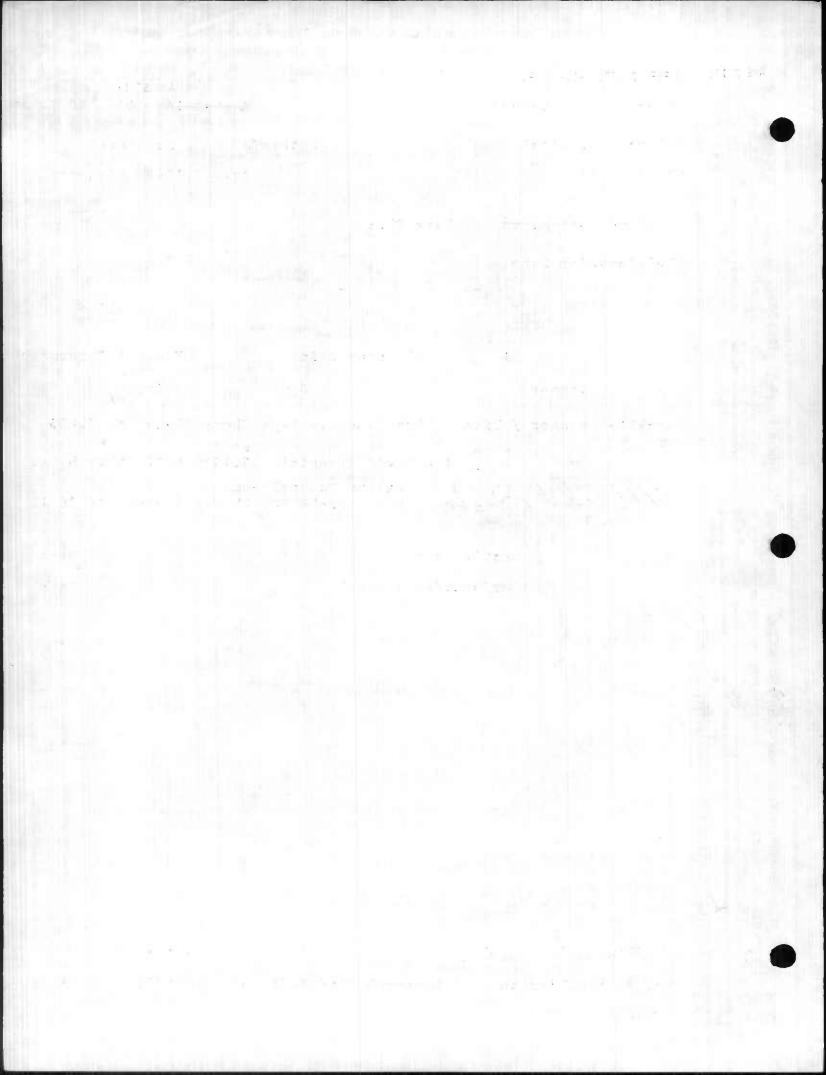
AUG 20 1999

SZ. Hegistrer's Signe

B. Sparks



AMEND ITE	۷. :	#2 PER MD G775 9-15-99		Marylar				l <mark>e</mark> alth a Death	ind Menta		iene 9 9	2	7157
		1. Decedent's Neme (First, Middle, L	ast)				•			le of Deet		13	3. Tima of Death
Physici /Medic		Abner B	renner						Aug	onth USE	1 d l	999	10:50 AM
Examin	_	4a Facility Name (If not institution, gi	ve street and num	ber)			4	4b. City, Tow	vn, or Location	of Deeth	4c. County	of Death	
		Suburban Hospi	tal					Beth	esda		Mont	g o m e	rv
Funeral			Sex 7	. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8. Dat	e of Birth		9. Birthp	place (State or Foreign
Director		578-58-8044	X 2□ F	91	Yrs.	WOTUTS	Days	riodis			1908		souri
2 >		Usuei Residence of Decedent 10a. Stete 10b. County		100 Ci	ty, Town or Lo	nation						4	0d. inside City Limits
enyler ehow	_	Toa. Stele		100. 01	ty, TOWITOT LO	Jation							XXYes 2 No
r 28a-f eh	Director	Maryland Montg	omery	Che	evy Ch	7	0.1					20	
with the Meryland ta or 28s-f show	ă	10a. Street and Number				10f. Zip	Code			10	g. Citizen of V	vnat Cour	nry r
a 234	Funeral	7204 Pomander	Lane	A	10 40 1		815		ing (Panella Va		S.A.	Amoria	ean Indian,
5-0020 72 hours effer death naturel; or forms 23	nu	11. Meritel Stetus	12. Wes Deced	ces?	i,S. 13. V	Yes, spec	ent of Hi	ispanic Orig en, Mexican,	gin? (Specify Ye , Puerto Rican,	etc.)		k, White,	
3 eft	by F	1 ☐ Never Merried 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or De	Λ	1	☐ Yes 2	No Mo	Specify:			Specify		
Maryland 21215-0020 d2 should be filed within 72 hours of the and Marial Hygiens and returnel; or Its marked other than "natural; or traumatic event, tra Houldel Example 1999.		15. Decedent's E		185.	16a. Deced	ant's Heug	l Occup	ation			16b. Kind of Bu	Whi	
15 n 72 n 72	Completed	(Specify only highest gi	rade completed)		(Give	kind of wor	k done d	during most	of working		TOD. TAILO OF DO	igii io 3 ar ii i	adeny
2121 d within piene.	Ë	Elementery/Secondary (0-12)	Coilege (1-	4or 5+)							Fodor	01 (Government
be filed hall Hygid of other		17. Fether's Neme (First, Middle, Las			Elec	LIOC	nem		r's Neme (First,				overnment
ylan buld be Mental mrked o	o Be	Max Brenn	or					Edna	2		Sing	er	
Marylar d 2 should be th end Menta 7 is marked traumatic ev	F	19a. informent's Name/Reletionship			19b. Mailin	a Address	(Street		r or Rural Route	Number.			(Code)
Mar d 2 sho ith end 7 is m traum				lfe					ne Che				
ore, Notes 1 and of Health of Health or other tr	r	Marcella Brenn 20a Method of Disposition	EI / WI		Place of Dispo- cemetery, crem				Date		20c. Location -		
DO D		1 1 Buriai 2 ☐ Cremetion 3 [(818					Augu	st			
Baltimore, permit. Peges 1 et Department of Hea important: If them any lojury or othe once.	-	4 Donetion 5 Other (Spec		Kir	ng Dav			rial ss of Fecility		999	Falls	Chu	rch, Va.
Ba Depa Mpo Mny l		21. Signature di funeral service Lice	many K	. 1					1 Home				
5)		11 Juelay	10/2	ele	25	4 Ca	rro	11 St	t. NW	Wash	ingto	n, I	C 20012
		23a. Part1. Enter the diseese, or cor shock, or heart failure. List only	nplicetions thet ca y one cause or ea	used the deal ch line.	th. Do not ente	er the mode	e of dyin	ng, such as o	cardiac or respi	retory arre	est,		Approximate Intervel Between
Physician													Onset and Deeth
/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	e Sept	ic Si	nock							- 1	2 Days
	_	resulting in death)		Due to (or es e conseq	uence of):						1	
D :=	line		Perf	orati	ion St	omac	h					1	2 Days
Box 68760, death certificate be executed enteroding physician and of for use as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (d	or es e conseq	uence of):							
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87 sate b	edical	thet initiated events resulting in death) Lest		Due to (d	or es a conseq	uenca of):							
ortifica ing ph	Me		d									1	
Box 68	Physician/M		0										
D. E	SC	Pert ii. Other eignificant conditione	contributing to dea	th but not res	sulting in the ur	ndertying ca	ause giv	en in Part i.	2:	3b. Did to	bacco uee coi	ntribute t	o the ceuee of death?
P.O. that the de deteched deteched	P									1 🗆 Y	2 No	3 Pro	bably 4 Unknown
ords, P requires thet sen signed b	þ						_						
Vital Records, slcian: The law requires to certificate has been signe irector, page 2 should be a	Completed								24	la. Was a	n eutopsy ned?	av	ere eutopsy findings vailable prior to
law re	ple											of	mpletion of cause death?
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Vital I	Bec	25. Wes case referred to medical						26. Place	of Deeth (Chec	ck only on	е)		
of Vita Physician: this certific	ToB	exa <i>m</i> iner? 1 ☐ Yes 2 ☒ No	Hospital: XIXIn	patient 2] ER/Outpetien	t 3 DO	A Oth	041	rsing Home 5			er (Specia	(v)
g Phys er this		27. Menner of Deeth	28e. Dete of		28b. Time of		8c. Injun				w injury occur		
이 분 - 속 호	5	1 Natural 5 Pending 2 Accident investigation		, Day Year)	injury	M		Yes 2 h	No				
Division To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not	200. Flace	of injury - At h	ome, ferm, str	et, fectory	, office		28f. Lo	cation (St	reet and Numb	er or Run	ai Route Number,
DIVI To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	ert	4 Homicide	buildin	g, etc. (Speci	<i>(y)</i>				Cit	ty or Towr	1, 51919)		
Hospital 14 hours Funeral tely filled	0	29a. Certifier 1□ Certifying P	hysician: To the b	est of my kno	owledge, death	occurred o	et the tin	ne, date and	d place, and du	e to the ce	ouse(s) and ma	inner as s	stated.
Hoo 24 h Fur etely	edical		miner: On the bas	sis of exemina									
within To the compl	Me	29b. Signeture epgl title of certifier	17			290	. Licens	e number		2	9d. Dete signe	d (Month,	Dey, Year)
F3Fŏ		D 4	1/ _	21			DSO	262			A11 G11 G #	13	1999
20	-	1. pnends	rusal	Xec.	00417		סכת	202		4	august	13	, 1995
		30. Neme end address of person who					7 1		# a 2 /. o	m -	. le = 4 1 1	0	MD 20850
		Dr. A. Mendhi 31. Dete filed (Month, Dey, Year)		gistrer's Sign		cn B	TAG	.Su1	Le 340	KOC	KVIII	e, 1	1D 20030
Sta	te	ALIC 1 py 100		accord a digiti	4	Ina	1	/					



State of Maryland / Department of Health and Mental Hygiene 9 9 9 7

			Certi	ficate of	Death	1	Reg. No.	C110	
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Elsie F. Brown					2. Dete of Dec Month	Dey	Year 3. Time of I	Deeth
Examiner	4a Facility Name (If not Institution, give so Manner Health of		Marylar		4b. City, Town, or L Clintor	ocation of Death	4c. County of	of Death e Georges	
Funeral Director	5. Sociel Security Number 5.77 – 30 – 7331 6. Sex	7. Age (In yrs		f Under 1 Year fonths Deys	tf Under 24 Hrs. Hours Min.	(Month, De	h y, Yeer) 28,1908	9. Birthplace (Stete or Country) Lynchbur	
eryland show	Usuel Residence of Decedent 10e. Stete 10b. County DC		City, Town or Local					10d. Inside City	
deeth with the Meryland ms 23s or 28s-f show finast be notified at neral Director	10e. Street end Number 3001 Bladensburg			10f. Zip Code 20018	3		10g. Citizen of W	het Country?	- T
j 22 j	1 Never Merried 2 Married 3 Midowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No It Yes, Give Yeer or Detes:		s Decedent of Fees, specify Cub	lispenic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)	Bleck	- Americen Indian, c, White, etc. Black	
Maryland 21215-0020 d 2 should be filed within 72 hours efter th end Mental Hygiena. 7 is marked other than "natural", or ite traumatic avent, me Medical Example To Be Completed by Fui	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th.	ation completed) College (1-4or 5+)	(Give kin	t's Usuel Occup d of work done NOT use retire	during most of world)	king	16b. Kind of But		
Maryland 212: d 2 should be filed within he and Mantal Hygiena. 7 is marked other than traumatic svent, the M	17. Father's Neme (First, Middle, Last) Charles L. Jone	S			Unknown		Maiden Sumeme		
e, Mary 1 and 2 sho Health end 1 me 27 is me when traum	19e. Informent's Neme/Reletionship (Type Idrelia Brown G		19b. Mailing	Address (Street 1 Blad	ensburg	RD.NE	, 20018	igton, bc Apt.100	1
S 5 5 5	20e. Method of Disposition 1 Durlal 2 Cremation 3 Re 4 Donetion 5 Other (Specify)	moval from State	Plece of Dispositi cemetery, creme! Lincoln	ory or other ple	1 1	Aug. 19		City or Town, Stete and, Maryl	and
Baltimo	21. Signature of Funeral Service License Onn W. Latine	1	348 La	tney's	Funera	l Home	,3831	Georgia A	ve.
Physician	23e. Pert1. Enter the diseese, or complic shock, or heart failure. List only one	ations that caused the dec cause on each line.	ath. Do not enter	SN-1-NGT the mode of dyi	on DC ng, such as cardied	or respiratory el	new.	Approximete Interval Betw Onset and D	veen Veeth
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) Mediate Media	tastatic (Cancer		abdomina	1		2 mont	hs
D, executed in end fal-transit Examiner	Sequentially list conditions		(or es a conseque						- 14
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events		(or es a conseque						
N See B	resulting In death) Lest	Due (0)	(or as a conseque						
law requires that the death celean celean signed by the attendit s. 2 should be detached for use appleted by Physician/R	Part II. Other significant conditions conti	ibuting to death but not re	esuiting In the unde	adying cause give	ven in Pert I.			tribute to the cause o	
00 0 5 5						perfo	en eutopsy med?	24b. Were eutopsy fit evailable prior to completion of ca of death?	ause
50 0	25. Wes case referred to medical exeminer?				26. Plece of Dec	1 Check only		1 ☐ Yes 2 ☐ I	NO
Physer this seral di	1 Yes 2 No No 27. Menner of Deeth 1 Naturel 5 Pending	aspitel: 1 ☐ Inpatient 2 [26e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju			denca 6 Other		
5 P# 5 E	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, stree cify)		100.7-	28f. Location (: City or To	Street end Numbern, State)	er or Rurel Route Numb	ber.
To the Hospital within 24 hours of to the Funeral Completely filled	29e. Certifier (Check only one) 2 Medical Examine	clan: To the best of my kr er: On the besis of examinand menner stated.	nowledge, deeth onetion end/or inves	ocurred et the ti	me, dete end plece opinion, deeth occu	, end due to the erred et the time,	ceuse(s) and ma date and piece, e	nner es stated. and due to the ceuse(s))
To the within To the comp	29b. Signature and title of cartifier	100		29c. Licens	se number		29d. Dete signed	(Month, Day, Yeer)	

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

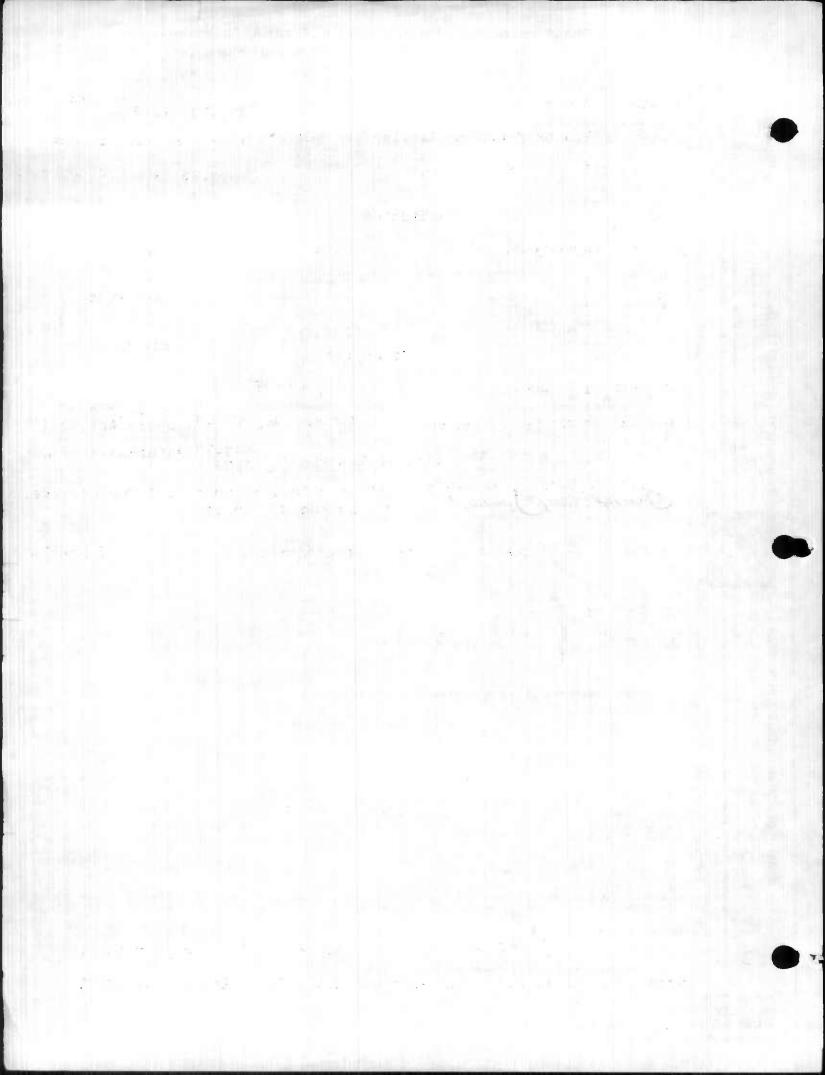
Suresh A. Patel, M.D. 7501 Surratts Road, 307 Clinton, MD. 20735

State Registrar

32. Registrer's Signeture

D46u78

August 18, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 17, 1999 4:40AM Brown August H. 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street and number) 4c. County of Death Circle Manor Kensington Montgomery 8. Date of Birth (Month, Day, Year) Jan. 22, 19 If Under 1 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 □ M 2 X F 1923 76 Kentucky 407-18-2955 Usual Residence of Deceden 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Chevy Chase Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 4750 Chevy Chase Drive #108 United States 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical U.S. Government 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Surname) Georgia Clark John H. Brown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles R. Brown/Brother 318 N. Townsend, Morganfield, Kentucky 42437 20b Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetery or other place)
August 20,
t. Ann's Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1999 4 ☐ Donation 5 ☐ Other (Specify) Morganfield, Kentucky 21. Signature of Funeral Service Licensee

22. Name and Address of Fecility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate Approximate Interval Between Onset and Death Immediate Ceuse (Final Atherosclerotic Coronary Vascular Disease Due to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and menner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) omes D34032 August 17, 1999 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 20895-2110

Physician /Medical Examiner that the deeth cartificate be axecuted physician and the bunal-tran P.O. Box 68760

Physician

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner, must be notified at

with the Maryland

deeth

filed within 72 hours after

permit. Peges 1 and 2 should be filed withit Department of Heelth and Mental Hygiene. Important: If fear 27 is marked other than eny Injury or other traumatic event.

Baltimore, Maryland 21215-0020

/Medical

Mary

10a. State

Maryland

12

disease or condition resulting in death)

1 Yes 2 1 No

27. Manner of Death

1 Naturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

Directo

Funeral

2

Completed

Be

Examiner Physician/Medical 80 esn 0 ped detach by Completed Be 10 Certification:

the

signed by t d be detact peeu aw. has page 2 certificate Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certific. funeral director, 24 hours a pletely filled To the Vithin 2

Division of Vital Records,

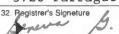
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State Registrar

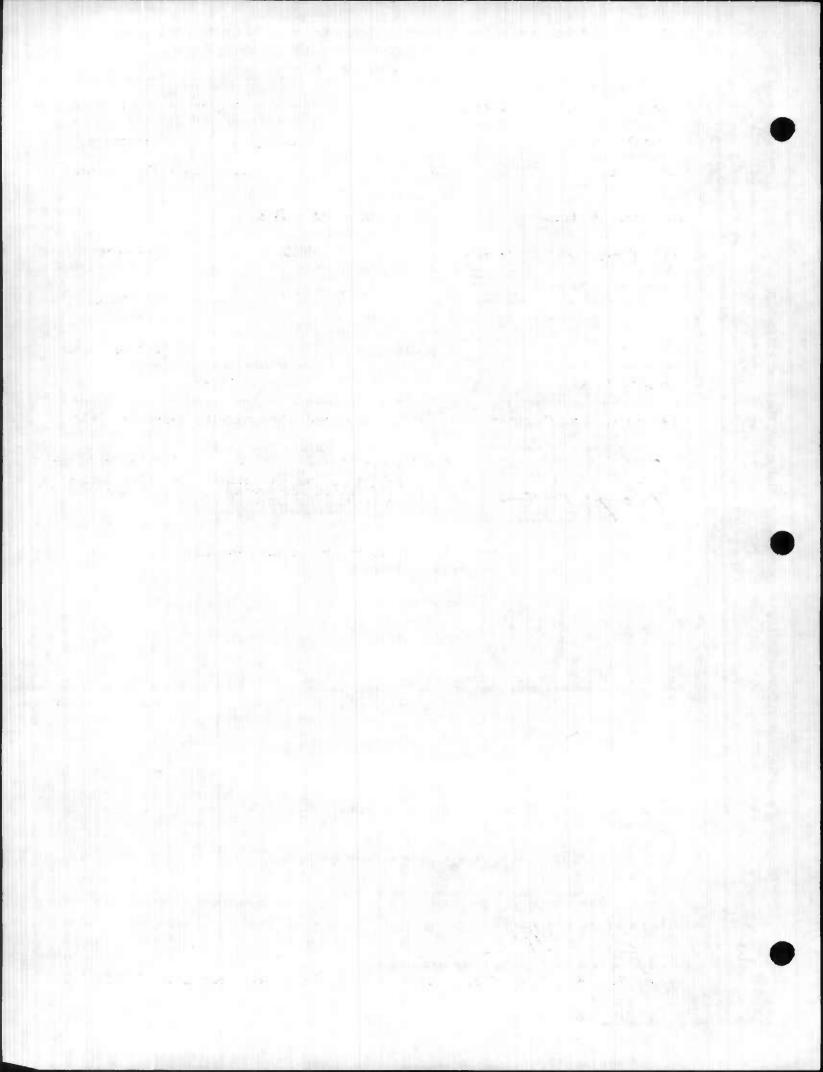
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31. Date filed (Month, Dey, Year) AUG 20 1999

Jeanne P. Asher, M.D.



3720 Farragut Avenue, Kensington, Maryland souks



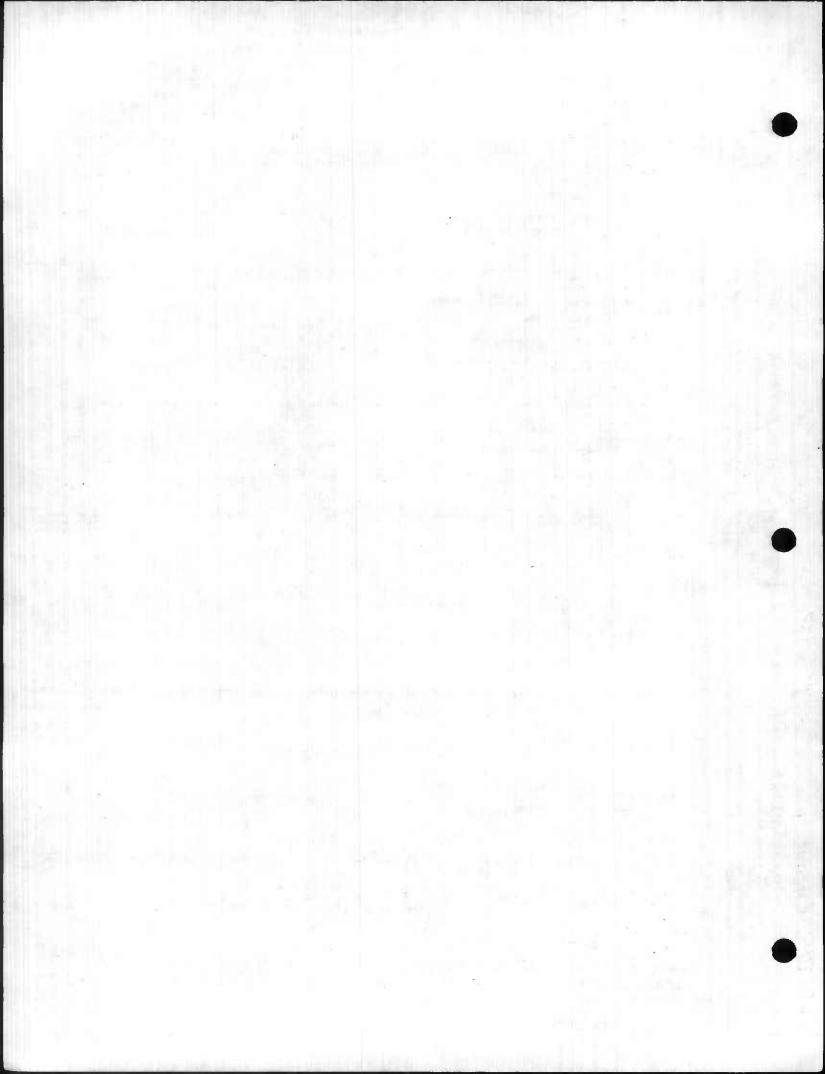
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month Day **Physician** LESTER Y. BURKE AUGUST 14, 1999 9:45PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs 5. Sociel Security Number 6. Sex № M 2□ F Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Deys Hours Months 230-03-5930 DEC. 11, 1921 Director VIRGINIA Usuel Residence of Deceden 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo MONTGOMERY OLNEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 17608 COAT BRIDGE PLACE 20832 USA **Пата** 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Stetus Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: WHITE ğ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT SUPERINTENDENT/PAINT SHOP permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important. If Nem 27 is marked other any injury or other treatmetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be CHARLES M. BURKE RIDER ALICE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (SON) DONALD BURKE 17608 COAT BRIDGE PLACE OLNEY, MD 20832 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State UNION CEMETERY 8-16-99 BURTONSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE 21 Signature of Funeral Service Licenses AVENUE SILVER SPRING, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one cause on each line. Approximete intervet Between Onset and Deeth **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or es a consequence of) Physician/Medical the Due to (or es a consequence of): 88 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? aucen 1 Yes 2 No 3 Probably 4 Unknown Records, Š Completed 24a. Wes an autopsy performed? 24b. Were autopsy tindings completion of cause of death? 1 Yes 28 No 1 ☐ Yes 2 ☐ No certificata Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 12Napatient 2 ER/Outpatient 3 DOA of this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? if or Attending is after death. 1/SNeturel Division 5 Pending 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

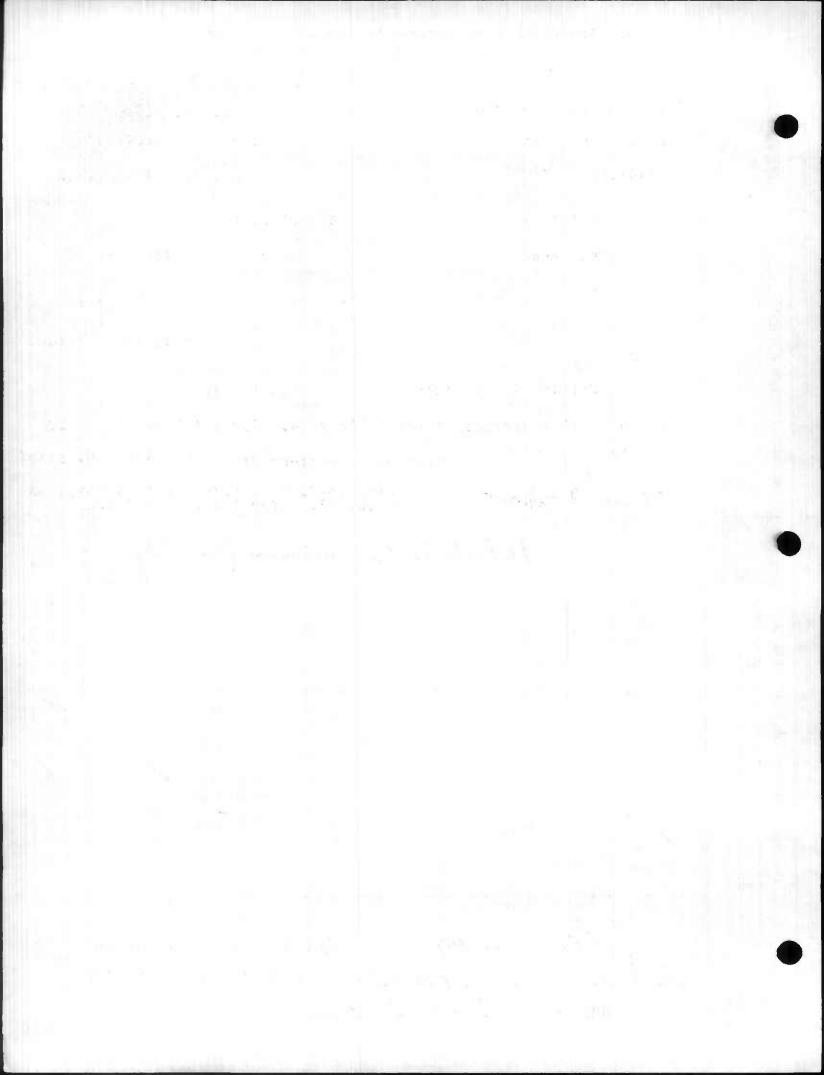
Danilo Molien' MD 6410 Rockledgo DV, #625 Bollosda MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State 17 1999 rocks Registrar

DHMH 16 Ray 6/95



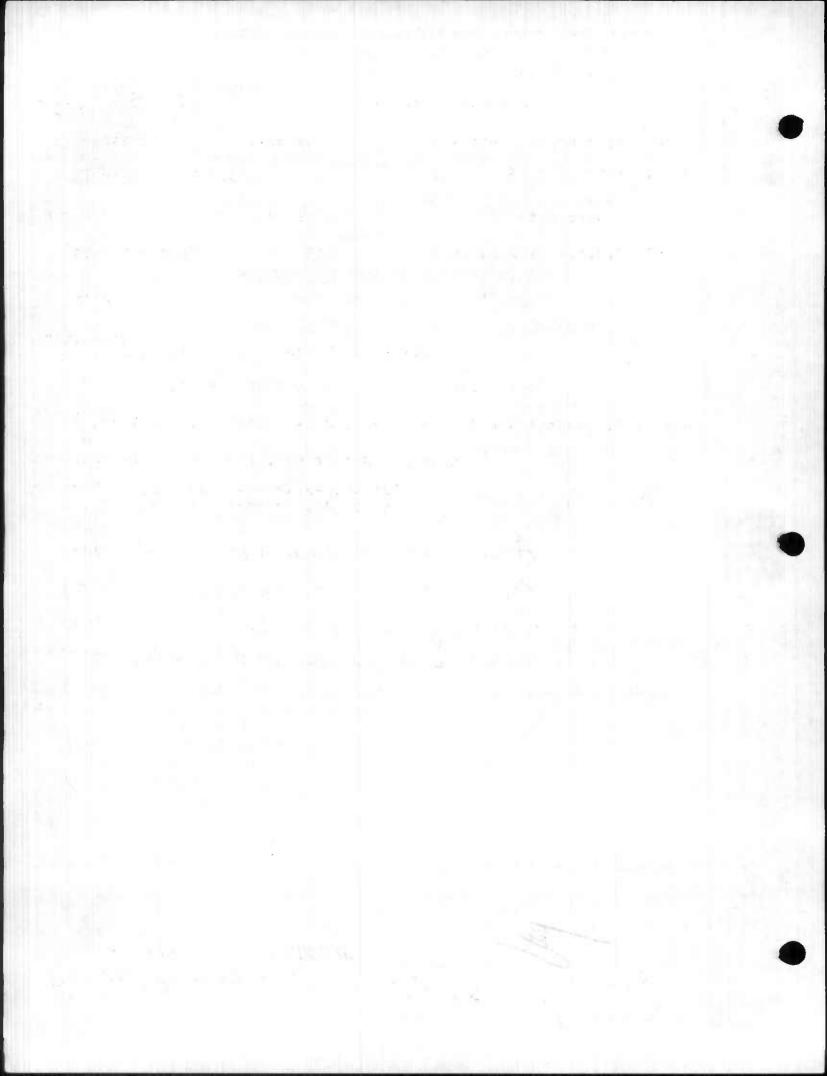
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27 | 6 |

				01010 01 1110	ily laria /	Certifica			F	leg. No.	hu j	
	Dharata		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Day	Yaar :	3. Tima of Death
	Physic /Medi		Thomas Vernon	Billings					1	0 . 19		1057
	Exami		4a. Facility Name (If not institution, giv	re street and number)				4b. City, Town, o	Location of Death	4c. County		
1			521 Liberty R	oad				Federal	sburg	Car	oline	
Γ	Funeral Director	П		Sex 7. Age	(in yrs. last	Month	der 1 Year ns Days	H Under 24 Hr Hours Mir	. (Month, Day	Year)	9. Birthplac Country	e (Stete or Foreign
			Usual Residence of Decedent	^	54				Aug. 20	,1944	Mary	land
	ylend		10a. Stata 10b. County		10c. City, To	own or Location					10d.	Inside City Limits
	Mar Thed	ģ	MD Carol	ine			Fe	deralst	urg			1 ☐ Yes 2 ☐ No
	1 th	Funeral Director	10e. Streat and Number			10f.	Zip Code		1	Og. Citizan of V	What Country	?
	th wil	ai	521 Liberty R	oad				21632		United	d Sta	tes
	dea F	ne	11. Marital Status	12. Was Decedent E Armed Forcas?	ver in U,S.	13. Was De	cedant of I	Hispanic Origin? (Specify Yas or No- rto Rican, etc.)		e - Amarican	
20	permit. Pages 1 end 2 should be filed within 72 hours effer death with the Marylend Depertment of Health and Meniel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evain net must be notified anone.	y Fu	1 Navar Married 27 Married	1 Yes 2 N	0		2 WNo		nto Alcan, etc.)	Specify	ck, White, etc	
21215-0020	ural.	d by	3 Widowed 4 Divorced	Year or Datas:							AA LI I	
15	"nat	Completed	15. Decadent's Ed (Specify only highest gra	ducation ade completed)		6a. Decedent's U (Give kind of	sual Occu <i>work do</i> ne	pation during most of wi ed)	orking	16b. Kind of Bu		
712	withi ene. then	E C	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Superv		70)		Build.	ing M	ainten.
D	Hyg Hyg offi-	Be C	17. Father's Nama (First, Middle, Last,)		0 4 5 0 1 1		18. Mother's Na	me (First, Middle,	Maiden Sumerr	ne)	
a	ould be Mentel arked o	To B	Willi	am T. Bi	llina	S		Ethe	1 Green			
Maryland	shou mand N	_	19e. Informant's Name/Relationship (ess (Stree		Pural Route Number		Stete, Zip Co	ode)
	end 2 saith a n 27 la		Joellen H. Bil	lings/Sp	ouse	521 Li	bert	v Rd.	Federal	shura	. MD	21632
ore	of Herrich		Joellen H. Bil 20a. Method of Disposition 1 Burial 2/Cremetion 3		20b. Place ceme	of Disposition (f	Vama of or other pla	ica)	Date	20c. Location -	City or Town	, Stata
Ĕ	Pages nent of I ant: If ite ury or of		1 ☐ Burial 2/☐/Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Cam	bridge	Cre	matory	8/13	ambri	dge, I	Maryland
Baltimore,	permit. Depertrimportu		21. Signature of Funeral Sarvice Licer	nsee		22. Nama	and Addre	ess of Facility				
0	20 5 5 8		Michael 7.	Theon		Fram	ptom	-Hawkir	s-Eskow	Funei	ral H	ome, PA
-		0. 1	23a. Part1. Enter the disease, or com shock, or heert feilure. List only	plications that caused	the death. D	o not entar the m	ode of dyi	ing, such as cardi	c or raspiratory arr	est,	Z I D S	oproximata terval Between
П	Physician		,	The second second							, ,	nset and Death
1	/Medicai Examiner		Immediate Cause (Final disease or condition	a. Heta.	tale	u Ca	u	nknow	n pri	mar	7	
	LAdiminei	Ļ	resulting In death)		Due to (or as	a consequence of	of):			1		
	beit sit	edical Examiner		b							i	
	tificete be executed ig physician and es the buriel-transit	хаг	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events		Due to (or as	a consequence of	of):					
68760,	sician burie	al	cause. Enter Underlying Cause (Disease or injury	c								
687	ficete phy s the	g	resulting in death) Last		ue to (or as	a consequence o	f):					
Вох	nding use e	2		d								
œ.	es that tha death cer igned by the ettendir be deteched for use	Physician/	Part II. Other significant conditions of	ontributing to death but	not resulting	n in the underlyin	n cause di	ven in Part I	23h Did to	haces use on	ntelbute to th	e cause of death?
Ö	t tha by th	hys		on the state of th	110110001111	g in the underlying	g oadse gi	VOIT IIIT OIÇT.				oly 4 DOnknown
Records, P.O.	gned oe de	by F										
ğ	= 0 D								24a. Was a perfor			autopsy findings ble prior to
900	ew requ	Completed							perior	/	compi of dea	letion of cause
	ician: The le certificete he rector, page	E							1 🗆 Y	es 22 No	1 D Y	es 2□ No
ta	lan: rtiflice ctor,	Be	25. Was case referred to medical					26. Place of De	eath (Check only of	ie)		
<u></u>	Physic this ce	2	examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatier	t 2 ER/	Outpatient 3	DOA Ot	her: 4 Nursing	Home 5 Reside	enca 6 Oth	er (Specify)	
2	ding Ph h. After th funera		27. Menner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey	Year) 28t	b. Time of Injury	28c. Inju Wo	ry at	28d. Describe h	ow injury occur	red	
<u>S</u>	endineth.	cati	2 Accident investigation			М		Yes 2□No				
Division of Vital	or Attending Physician: offer deeth. Director: After this certific in by the funeral director,	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Placa of Inju- building, etc.	ry - At home, (Specify)	, farm, street, fact	ory, office		28f. Location (Si City or Town		er or Rural R	oute Number,
	urs e urs e ral D											
	To the Hospital or Attending Physician: within 24 hours effecteeth. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of	examination	lge, death occurre end/or Investigati	ed at the ti on, in my o	me, date and pled opinion, death occ	e, end due to the curred at the time, d	ause(s) end ma ate and placa, a	nner as state and due to the	id. B cause(s)
	To the within 2 To the comple	Mec	29b. Signature and the of conflict	end manner stet	ed.		9c. Linen	se number		9d. Date signer	d (Month Des	e Year)
	F 3 F 8		1/1/4	nanu	un	1	1	859	0=	1-1	1-61	,
•			20 Name and				- /	011	PC	0 1	17	-
	Ш		30. Name and address of person who	1 1 1 10	ath (Item 23s	a) (Type, Print)	fun	KD. S	espel 6	02 18	973	>
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	's Signature	1	,		/			
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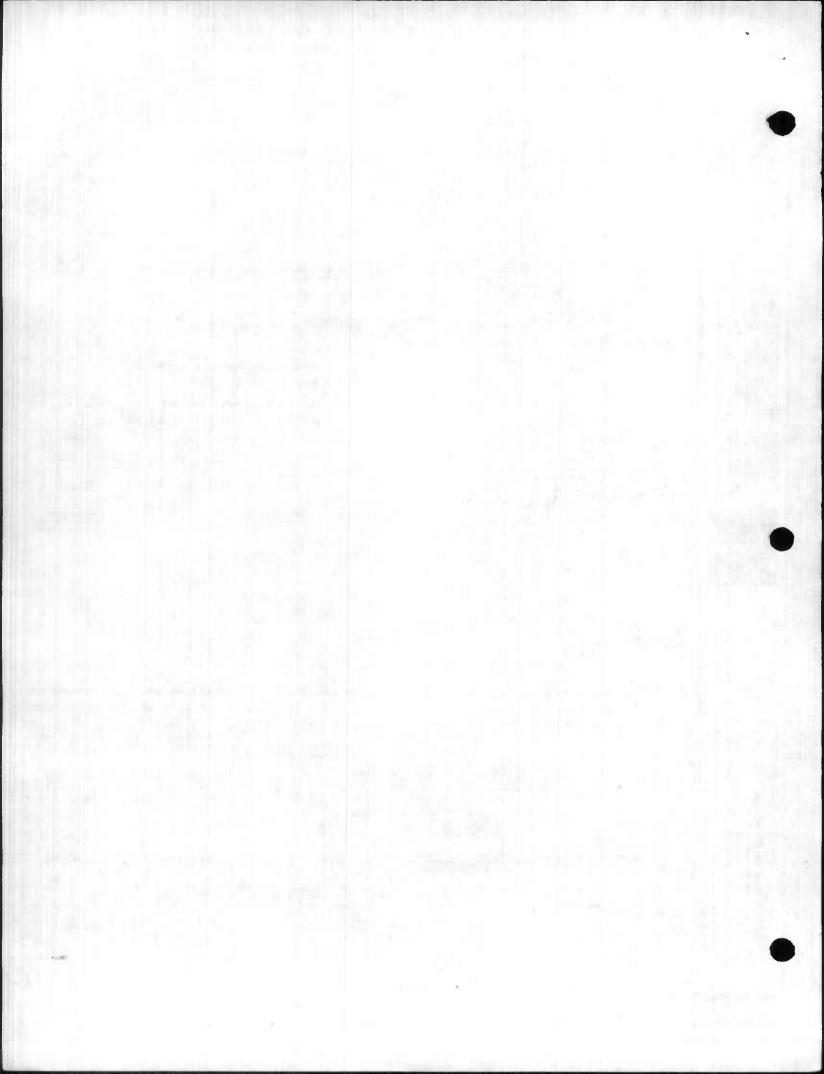


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					Ce	rtificate o	f Death	F	leg. No.		
П	Physic /Medi		1. Decedent's Neme (First, Middle, Last)					2. Dete of Deeth 3. Time of Death			
ı			Margaret Louise Bell					A U.G.	18. 199	Yeer 1935	
	Exami		4e. Facility Neme (If not institution, give street and number)				4b. City, Town, or I		4c. County of		
1			Dorchester General Hospital				Cambr	ambridge Dorchester			
a.	Funerai Director		216-10-4594 1 M 2 SE 83 Yrs. Months			Months Dey					
	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f show fre Macical Examiner must be notified at	ector	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City								
215-0020									1 ☐ Yes 2 ☒ No		
		Funeral Director	6637 E.N.Mkt-Ellwood Road				21643		10g. Citizen of Whet Country? United States		
		by	11. Maritel Stetus 1 Never Merrled 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes:	r in U,S. 13.	Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	Hispenic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White	
		Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16e. Dece	edent's Usual Occ	upation	kina	16b. Kind of Busi	Iness/Industry	
		du	(Specify only highest grade completed) [Give kind of work done during most life. DO NOT use retired) [College (1-4or 5+)] [College (1-4or 5+)]					1101 011 001		Dorchester	
121	Hygier ther th		12 Cafeteria Worker					High School			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, If a Media.	Be	17. Father's Neme (First, Middle, Last)	Caman Dam	an an da da			ne (First, Middle, i)	
		T _o									
			19e. Informent's Neme/Reletionship (Ty								
			Brenda B. Winds 20e. Method of Disposition							ity or Town, Stete	
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Bal			21. Signeture of Funeral Servica Licansee 22. Name and Address of Fecility Framptom-Hawkins-Eskow Funeral Home, Property Address of Fecility Framptom-Hawkins-Eskow Funeral Home, Property Address of Fecility								
	death certificate be executed By American and Common physician and Comm	Examiner	23e. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset end Deeth								
ivision of Vita				Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury							
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			Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
		Completed b						24e. Wes an eutopsy performed? 24b. Were autopsy findings evellable prior to completion of cause of deeth?			
	0 - 0	mo:						1 🗆 Y	es 2 No	1 Yes 20 No	
	or Attending Physician: ther death. Irector: After this certific In by the funeral director,	BeC	25. Wes case referred to medical				26. Plece of Dee	th (Check only on	10)		
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			27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year) 28b. Time of Nork? Injury M 28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify)			28d. Describe how injury occurred				
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. Check only one) Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted.								
	To the To the Comp	M	29b. Signeture end title of contribor 29c. License number					29d. Date signed (Month, Dey, Year)			
			7500				50987	7 8/23/99			
			30. Name and address of person who completed cause of deeth (Item 23e) (Typa, Print) Ahmed Nauro 105 Auror Street Cambridge, MO 216/3							MOSUL	
			Ahmed	Nauvy	1105 7	Auroria	Street	cam	mage,	1100 216B	
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sician				Cen	illicate	of Dea	ith		Reg. No.		
sician	1. Decedent's Neme (First, Middle	, Last)						2. Dete of Dea	ath		3. Time of Death
12 . 4	EDWIN M.	COHEN						Month	Day 10,1999	Year	10:20 PM
edical miner	4a Facility Neme (If not institution,		ber)			4b. City	, Town, or Lo	cation of Death	7		10.20 11.
mmer	SUBURBAN HO						BETHE	SDA	MON	TGOM	FRV
			. Age (In yrs. la:	st birthday)	If Under 1 Y	ear If Un					
di .	578-38-8947	1₩ 2□F	69	Yrs.	Months De	ys Hou	urs Min.	8. Date of Birt (Month, Day AUG 19	1929	MARY	ace (State or Foreign hy) T.A.N.D.
	Usual Residence of Decedent								, -, -,		
	10a. State 10b. County	7	10c. City,	Town or Loc	ation					10	d. Inside City Limits
ò	MARYLAND MONTO	GOMERY	GA	ITHERS	SBURG						1 ☐ Yes 2 ☐ No
Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen of V	Vhat Coun	lry?
	16733 SIOUX	X LANE			20	878			UNITE	STA'	res
96	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. W	/es Decedent	of Hispanio	Origin? (Sp	ecity Yes or No-	14. Race	e - America	an Indian,
2	1 Never Married 2 Marrie	ed 1 NYes 2 If Yes, Give		- 0	Yes, specify			Rican, etc.)	Blac	k, White,	etc.
p	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Da	es:	1	☐ Yes 2[X]	No Spe	city:		Specify	WHI	TE
B	15. Decedent	's Education	1	16a. Decede	ent's Usuei O	cupation			16b. Kind of Bu	siness/Ind	lustry
Completed	(Specify only highest Elementary/Secondary (0-12)		for Eal	(Give k	ind of work do O NOT use re	one during (stired)	most of work	ing			
E	cheminary/Secondary (0-12)	College (1-		SAI	LES MAN	IAGER			AUTOMOT	IVE .	
Bec	17. Father's Name (First, Middle, L.	Last)	-			18. M	lother's Nemo	e (First, Middle,	Maiden Sumam	10)	
ToB	HERMAN COH	EN				F	ROSE BI	ERNSTEI	N		
	19a. Informant's Name/Relationsh	nip (Type Print)		19b. Mailine	Address (SI	reet and Nu	mber or Run	al Route Numbe	or, City or Town,	State. Zio	Code)
		(WIFE)							JRG, MAF		
1	20a. Method of Disposition	(11222)	20b. Ple	ce of Dispos	ition (Neme o	1		Dete	20c. Location -		
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_	21. Signature of Funeral Service L.	Licensee	1	DA	Name and A NZANSI	Y-GOI	DBERG	MEMORIA	AL CHAPE	ELS,	INC.
	Journa !	Men	Du	11	70 RO	KVILI	E PIKI	E - ROCI	KVILLE,		LAND 20852
	Pert1. Enter the disease, or o shock, or heart feilure. List of	complications that ca only one cause on ea	used the deeth. ch line.	Do not ente	r the mode of	dying, such	h as cardiac	or respiratory ar	rest,		Approximete Intervel Between
	()									1	Onset and Death
	Irimediate-Cause (Finel disease or condition		Myocard	hal 1.	nfarct	un.	CVA			i	1 Day
	resulting in death)	a		es e consequ		-/-			ALL YES		
ine in			CAD								
Examiner	Sequentially list conditions, if any, leading to immediate	0	Due to (or a	is e consequ	ence of):						
	is any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		HTH								
edical	that initiated events resulting in death) Last	с		s a consequ	ence of):					1	
Mec			CA							- !	
	· ·	d								1	
Physician	Pert II. Other algnificant condition	na contributing to dea	th but not result	ing in the un	derlying caus	given in P	Pert I.	23b, Did 1	obacco use co	ntribute to	the cause of death
J.								10	Yes 2 No	3 Seriot	ably 4 Unknow
X											
0									en autopsy med?		ere autopsy findings allable prior to
ed by								perio	imeur	COL	npletion of cause seath?
pleted b								101	res 2000	15	Yes 2 No
ompleted b											7 195 213190
Completed	25. Was case referred to medical					00.0		h (Check only o			
Be Completed	25. Was case referred to medicat examiner?	Hospitei: No e	075	0/0 1	a□ 204	Other		- · · · · · · · · · · · · · · · · · · ·		10	
To Be Completed	examiner?	100		R/Outpatient		Other: 4	☐ Nursing Ho		dence 6 □Oth		1)
To Be Completed	examiner? 1 Ves 2 No 27. Manner of Death 1 Naturel 5 Pending	28e. Dete of		R/Outpatient 8b. Time of Injury	28c.	Other: 4 [Injury at Work?	Nursing Ho				')
To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Nature 5 Pending 2 Accident investige 3 Suicide 6 Could no	28e. Dete of (Month)	Injury 2 Day Year)	8b. Time of Injury	28c.	Other: 4 Injury at Work?	Nursing Ho	28d. Describe I	dence 6 Oth	red	
To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pending investige	28e. Dete of (Month) pot be 28e. Place of	Injury 2	8b. Time of Injury	28c.	Other: 4 Injury at Work?	Nursing Ho	28d. Describe I	dence 6 Oth	red	
Certification: To Be Completed	examiner? 1	28e. Place of building	Injury Day Year) of Injury - At homg, etc. (Specify)	28b. Time of Injury	M 28c.	Other: 4 [Injury at Work? 1] Yes :	Nursing Ho	28d. Describe I 28f. Location (S City or Tox	dence 6 Oth now injury occurr Street and Numb in, Stete)	red ner or Rura	l Route Number,
Certification: To Be Completed	examiner? 1	28e. Place of building g Physician: To the bear	Injury Day Year) of Injury - At home and the control of the contr	28b. Time of Injury	28c. M et, fectory, of	Other: 4 [Injury at Work? 1] Yes :ice	Nursing Ho	28d. Describe I	dence 6 Oth now injury occur of the street and Numbern, Stete)	ner or Rura	I Route Number,
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ledical Certification: To Be Completed	examiner? 1	28e. Dete of (Month letion not be ined 28e. Place of building Physician: To the bas and menne	Injury Day Year) of Injury - At home and the control of the contr	28b. Time of Injury	et, fectory, of occurred at the estigation, in a	Other: 4 [Injury at Work? 1] Yes :ice	Nursing Ho 2 No e and place, deeth occurrence	28f. Location (Scity or Townson due to the red at the time,	dence 6 Oth now injury occur of the street and Numbern, Stete)	ner or Rura	I Route Number, ated. the cause(s) Day, Year)
ledical Certification: To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Nature 5 Pending investige 2 Accident 6 Could ned telemin 29a. Certifier (Check only one)	28e. Place of building g Physician: To the bear	Injury Day Year) of Injury - At home and the control of the contr	28b. Time of Injury	et, fectory, of occurred at the estigation, in a 29c. Lie	Other: 4 [Injury at Work? 1 [Yes : ice	Nursing Ho 2 No e and place, deeth occurrence	28f. Location (Scity or Townson due to the red at the time,	dence 6 Oth now injury occur Street and Numb In, Stete) cause(s) and madate and place,	ner or Rura	I Route Number, ated. the cause(s) Day, Year)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Hans Cahnmann 08-15-1999 3:00AM 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 5430 Beech Ave. Bethesda Montgomery # Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1QM 2□F 93 126-14-3698 01-27-1906 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits X☐ Yes 2☐ No Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20814 US 5430 Beech Ave. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 5+ Research Chemist Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Sigwart Cahnmann Hedwig Schulein t 9e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5430 Beech Ave. Bethesda, Md. 20814 Ruth Cahnmann/ Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) Judean Memorial Gardens 08-17-99 Olney, Md. 21. Signature of Funeral Service Licensel 22. Neme end Address of Fecility Edward Sagel Funeral Direction, INc. 23e. Pert1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervet Between phock, or heart fellure. List only one cause on each tine. immediate Cause (Final neumonia disease or condition resulting in deeth) Due to (or es a consequence of) heart stive Due to (or es a consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas (2K) No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1□ Yes ŒNo 1 Yes 20 No 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home & Residence 6 Other (Specify)

Physician /Medical Examiner

Completed

Be

Certification:

edical

Physician

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be 2

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

the Manyland

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: if Nem 27 Is marked other than in any Injury or other traumation.

Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

4 Homicide

29a. Certifier

cerebrovascular accident adrial Ebrillation

1 Yes ON No 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of Neturel 5 Pending 2 Accident investigation 6 ☐ Could not be determined 3 Suicide

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signeture end title of certifier) when

29c. License number

28c. Injury at Work?

OK Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) (0215 Fernood (d #100 Between Ad 200,7. BANGCU SUSAN

31. Date filed (Month, Day, Year) AUG 16 1999 32. Registrar's Signature

State

Division of Vital

Attending

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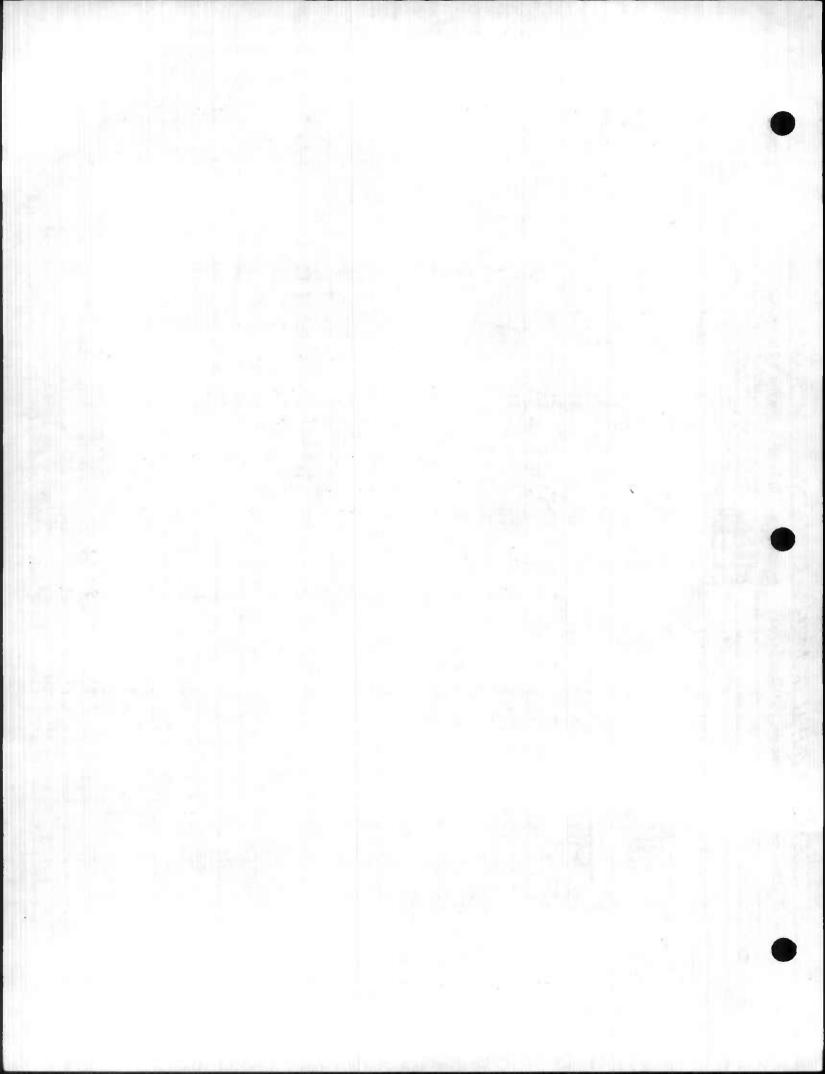
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after death.

within 24 hours after death To the Funeral Director:

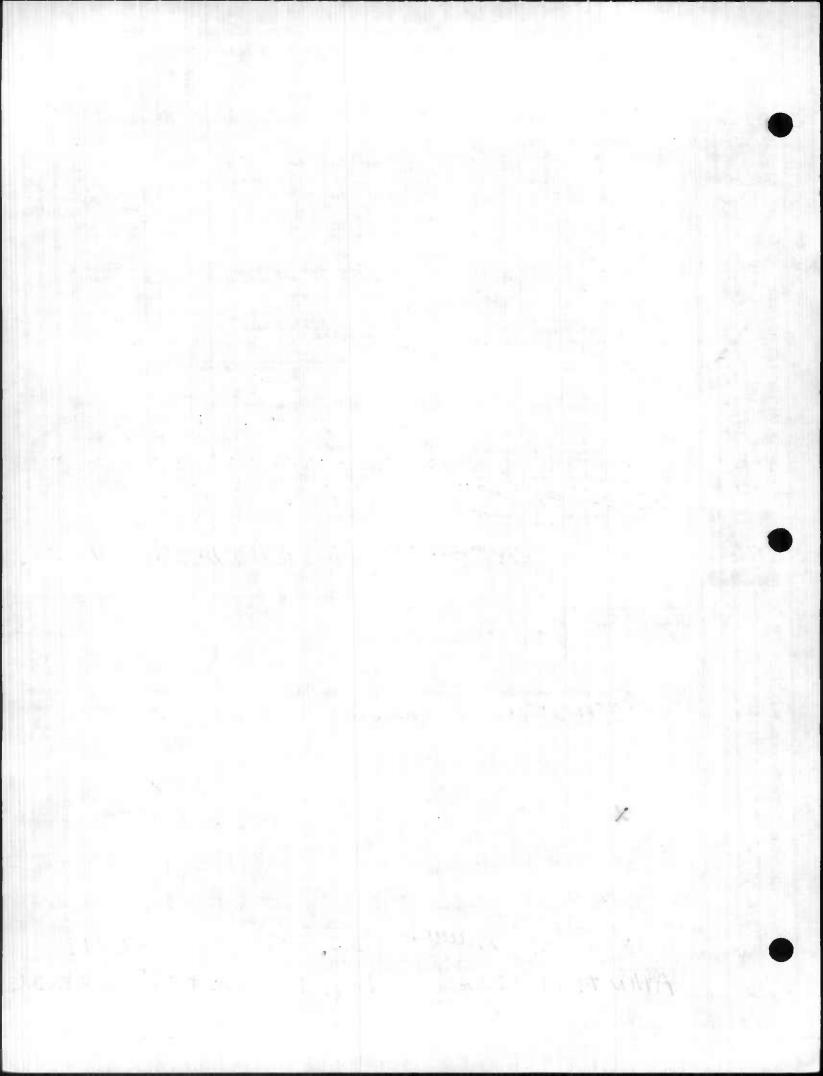
After this



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Ruth Waldman 08-16-1999 Camacho 3:00PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA 6420 BRADLEY BLVD Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7.08.1931 Birthplace (State or Foreign Country) NTV **Funeral** Days 1 M 2 F NY 68 Director 083.24.3055 Usual Rasidence of Deceden 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Maryla 1 Yes 2 No Director 288-1 MARYLAND MONTGOMERY BETHESDA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò USA 6420 BRADLEY BLVD 20817 Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Merital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 1 No
If Yes, Giva
Year or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 'natural', or WHITE Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1=for 5+) MEDICAL PHYSICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama /First Middle Last! permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumetic event Be SUSAN WAGNER JOSEPH WALDMAN 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1010 5th AVENUE, NEW YORK, NEW YORK 10028 ALEX CAMACHO/SON 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 DBurlel 2 Cramation 3 Removal from Stata PARKLAWN/MENORAH GARDENS 8.18.99 ROCKVILLE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CANCER OF THE STOMPC4 /Medical Immediata Causa (Final disease or condition rasulting in daath) Examine Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the Due to (or as a consequence of): P.O. 9 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? eTes MELLITUS 1 Yes 21300 3 Probably 4 Unknown been signed t should be det Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Desidence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Medical Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? After 1 Accident 5 Pending within 24 hours after death.

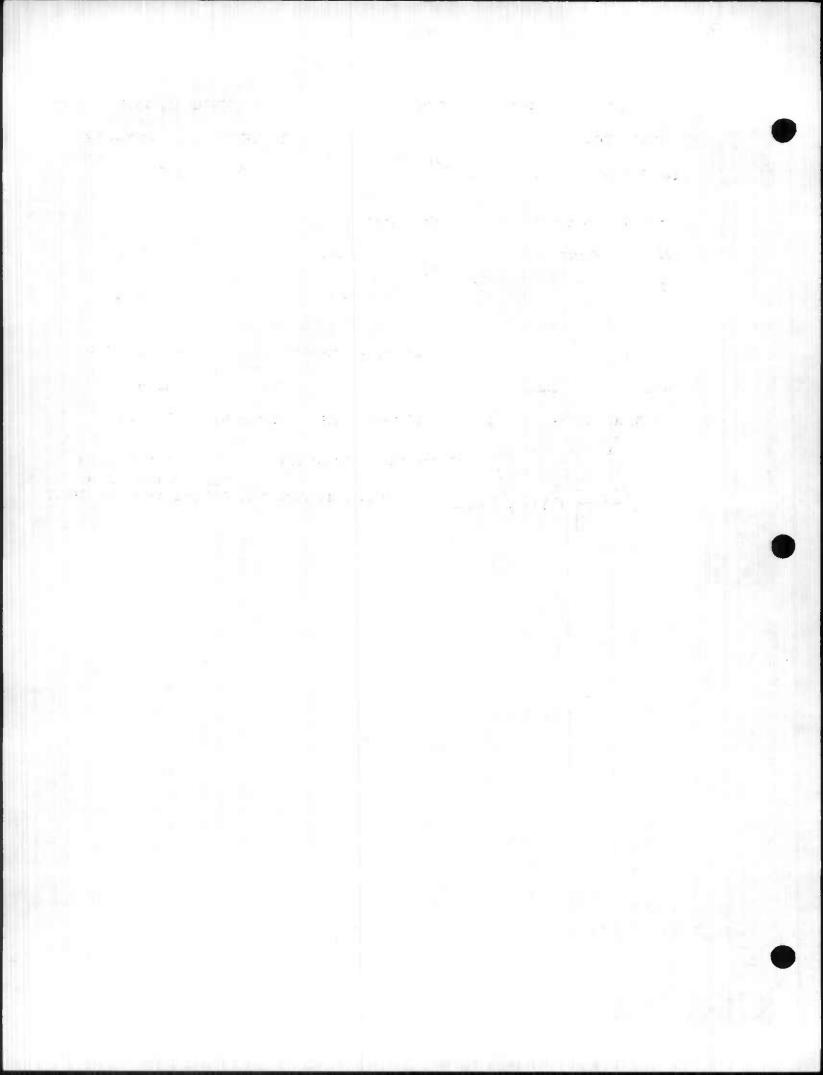
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No invastigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated. occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signeture and titla of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D.C. 382 40 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) WASH. D.C. MONDZAC K JT, N.W. \$707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 18 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 271

Certificate of Death

			•	Certificate of l	Death	Reg. No.	21100
		1. Decedent's Name (First, Middle, Last)			2. Dete of Month		3. Time of Death
	Physician /Modical	1118	YUN CHO	OU	AUGU		1:23 AM
	/Medical Examiner	do Contito himma /// and institution sine a	itreet end number)	4	b. City, Town, or Location of De	ath 4c. County of De	eth
		52 NINA COURT			GAITHERSBURG	MONTG	OMERY
	Funeral Director	5. Sociel Security Number 214-17-0316 Usuel Residence of Decedent	7. Age (In yrs. las	st birthday) If Under 1 Year Months Deys	Hours Min. 8. Date of (Month, Oct 4		Birthplace (Stele or Foreign Country) hina
	pung m	10a. State 10b. County	10c. City,	Town or Location			10d. inside City Limits
	Mary Media	Maryland Montgomer	·v G:	aithersburg			1 Yes 2 No
	vith the Ma or 28a-fr be notified	10e. Street and Number)	10f, Zip Code		10g. Citizen of What	Country?
	death with the Maryland one 23s or 28s-f show critist be notified at neval Director			2087	7	United St	ates
	r Nerre 23a iner must	11. Marital Stetus	12. Wes Decedent Ever in U.S.	. 13. Was Decedent of H	ispanic Origin? (Specify Yes or in, Mexican, Puerto Rican, etc.)	No- 14. Race - Ar	merican Indian,
Maryland 21215-0020	or after at, or its Examine	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2Ã No		Specific:	Asian
50	ed within 72 ho ygiene. her than "naturn it, the Medical.] Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occup.	ation during most of working	18b. Kind of Busines	ss/Industry
2	within ene. than ' he Mac	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	(Give kind of work done of life. DO NOT use ratired			
2	filed w Hygier ther th ent, the	12		Owner/Proprie		Retail S	ales
Pu	E dath	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Midd		
yla	s ahould be and Mental a marked o sumatic eve To Bu				Chu	Zhang	
Aar	2 sh is m is m	19a. Informant's Name/Relationship (Type	pe, Print)		and Number or Rural Route Nur		
	1 and Health em 27 other fr	Hua Chou, father	non Ple		, Gaithersbur	T	
Baltimore,	Pages ment of ant: If it ury or o	20a. Method of Disposition 1 Burial 2 A Cremation 3 Re 4 Donation 5 Other (Specify)	emovai parili arilini	ca of Disposition (Name of metery, crematory or other plec ropolitan Crem	1000	20c. Location - City Alexandri	
Balt	permit. Dispart Import any inj ance.	21. Signature of Juneral Septice biconse		22. Name and Addres	DeV Park Dr., Gai	ol Funeral	
		23a. Part1. Enter the disease, or complications shock, or heart failure List only on	cations that caused the death.				Approximate interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a	Gunshol	as a consequence of):	to head		Onset and Death
	pa sit	b	I				1
,00	law requires that the death certificate be assocuted as been signed by the attending physician and 5.2 should be detached for use as the burial-transit poleted by Physician/Medical Examination	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c	Due to (or a	as a consequence of):			
68760,	ntificate to ng physic as the b	that initiated events resulting in death) Last	•	as a consequence of):			
Box	attendir attendir for use	d					
O. E	the at the A	Part II. Other significant conditions con-	tributing to death but not result	ting in the underlying cause giv	en in Part I. 23b. D	ld tobacco use contrib	ute to the cause of death?
P.	that the death celled by the attendit detached for use	Tondue can	CRI		1	☐ Yee 2☐ No 3☐	Probably 4 Unknown
S,	tras the signer be d						L 186
Records,	The law requires that sate has been signed by page 2 should be detailed.				24a. W	as an autopsy 24 orformed?	b. Were autopsy findings available prior to completion of cause
ec	has b						of death?
E E	The page				1	□Yes ŽŪNo	1 ☐ Yes 2 No
/ita	Physician: rthis certific iral director,	25. Was case referred to medical examiner?	Inner And	l Out	28. Place of Death (Check on	ly one)	
5	hysic this cal direct	112 Yes 2 No	1	R/Outpatient 3 DOA Oth	4 LI Nursing Home 5 A	esidence 8 Other (S	pecify)
n	ing P	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wor		be how injury occurred	amalat wound
Sio	Attending or death. octor: After by the funa	2 Accident investigation 3 Suicide 6 Could not be	August 12,1999	0123 hrs, 10	7	TIM TICTER	gunshot wound
Division of Vital	to or Attending P is after death. In Director: After ted in by the funara Certification:	4 ☐ Homicide determined	building, etc. (Specify)	ne, farm, street, factory, office	City or	(Street and Number of Town, State) 52	Vina Court
	oral Ce		nome			rensburg, w	D 20877
	n 24 hound no 24 hound he Funer pletely fill edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Examin			ne, date and place, and due to t pinion, death occurred at the tin		
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29b. Signeture end title of certifier	and mariner stated.	29c. Licens	e number	29d. Date signed (Me	onth, Day, Year)
	F3F8	Delinia U	Tour har ha	DS 105	1916	Andreal	11 1000
	5	ramcia 2.	10 meyer 111	Co (Time Petri)	1110	Mugust	12, 1779
_		30, Name and address of person who co	omn 11140 K	OCKVILLO DIL	e #348 Rock	ille MD 1	1850
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire /	J O 10 MOOND	in juil de	1000
	Desistance	AUC 1 6 1000	Deneva	19 Asan	,		



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Please	Fype or Pri State of M									pr	gible	27	167
		•	Cer	tificate	of I	Death			Re	g. No.		tota 2	
1. Decedent's Name (First, Middle, Last)							2. Date o	f Death			3. Ti	me of Death
JOHN NENZEL CONWAY								AUB	UST	Day	199	9 2	50/pm
4a Facility Name (If not institution, give	street and number,				4	b. City, To	wn, or L	ocation of E	Death	4c. Cou	inty of [Death	
FALLSTON GENERAL H	OSPITAL				F	ALLSI	ON			HAR	FORI)	
5//-10-2048	x 7. Ag XM 2□F	je (In yrs. last l	Vre	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month) MAY	, Day,			Birthplace (S Country) IRGINIA	tate or Foreign
Uaual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation								10d los	ide City Limita
Toal. State		100. City, 10	WII OI LO	Cation									
MARYLAND MONTGOMER	Y	ROCKV	LLLE										Yes ZXXVo
10e. Street and Number				10f. Zip 0	Code				10	g. Citizen	of Wha	t Country?	
13210 DUMBARTON DR	IVE			2085	3					AME			
11. Mentel Stetus	12. Wes Decedent	Ever in U,S.	13. \	Vas Decede	nt of H	spanic Ori	igin? (Sp	ecify Yes o	r No-	14. F	Race - /	American Indi	an,
1 Never Married XX Married	Armed Forces		-	f Yes, specif				Hican, etc.	.)			Vhite, etc.	
3 Widowed 4 Divorced	If Yes, Give Yeer or Dates:	1946	1	I ☐ Yes 2	XIX o	Specify:				Spe	city:	пттг	
15. Decedent's Edu	THE CONTRACT			ient's Usual	Occino	ation			1	6b. Kind o		HITE ess/Industry	
(Specify only highest grad	e completed)		(Give	kind of work	done o	luring mos	t of work	ing					
Elementary/Secondary (0-12)	College (1-4or								-	EPCO			
12th 17. Father's Name (First, Middle, Last)		11	SIK	JMENT_	KEP		do Alom	e (First, Mi			nama!		
17. Father's Ivame (First, Micore, Last)						TO. MOUTH	at 5 (Vall)	e (First, IVIII	gure, m	eideri Suii	rarne/		
JOHN NICHOLAS CONW	AY					IREN	IE E	GAN					
19a. Informent's Neme/Relationship (T)	rpe, Print)	15	9b. Meilin	g Address (Street	and Numb	er or Ru	ral Route N	umber,	City or To	wn, Sta	te, Zip Code)	
BETTY M. CONWAY (W	IFE)	13	3210	DUMBA	RTO	N DRI	VE I	ROCKV	ILLE	MAR	YLAN	ND 2085	53
20e. Method of Disposition				sition (Name		-1		Date		Oc. Locatio	on - City	or Town, Sta	ite
XIX Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)				natory or oth MEMOR I			i 4	AUG. 14 1999	-	LNEY	MAI	RYLAND	20853
21. Signature of Funerel Service Lipens	88						y HI						Æ, INC
A Samo Seh	Wait.	/					118		N HA	MPSH:	IRE	AVENUE	_
23a Rant / 5 ter the disease, or complete him to heert feilure. List only of	icetions that sause ne cause on each l	d the death. Done.	o not ente	er the mode	of dyin	g, such as						Appro	ximate al Between and Death
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disease or condition resulting in death)					-141		1	MILL	114			i	
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Cause (Disease or Injury	o												
that initiated eventa resulting in death) Last		Due to (or as a	conseq	uence of):									
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PERIPHERAL			۲ ۱	DISE	745	E				a 200/N		□ Probably	
CEREBRUVAS	CUAR	4 cc	IDE	ENT					Was an	autopsy ed?	2	available	n of cause
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25. Wes case referred to medical			_			26. Place	of Dea	th (Check o	nly one)			
examiner?	fospital: 1 ☐ Inpati	ent 2 DERVO	Dutantian	t 3□ DO/	Oth	w-		ome 5 🗆 I			Other /	Canalki	
				S JLILKIA									

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral Director

death with the Maryland

pernit. Pages 1 and 2 should be filed within 72 hours attac death with the Marylar Dopartment of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or flams 23s or 28e-f show any injury or other treumetic event, the Medical Examines must be notified at

Baltimore, Maryland 21215-0020

tmmediate Ceuse (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in death) Last and

signed by the attending physician d be detached for use as the buris Medical Certification: To Be Completed by Physician/Medical To the Mospital or Attending Physician: The within & A hours attended.

To the Funeral Director After this certificate to completely filled in by the funeral director, page completely filled in by the funeral director, pag

(MU)内Y, FOHN Division of Vital Records, P.O. Box 68760,

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State

Registrar

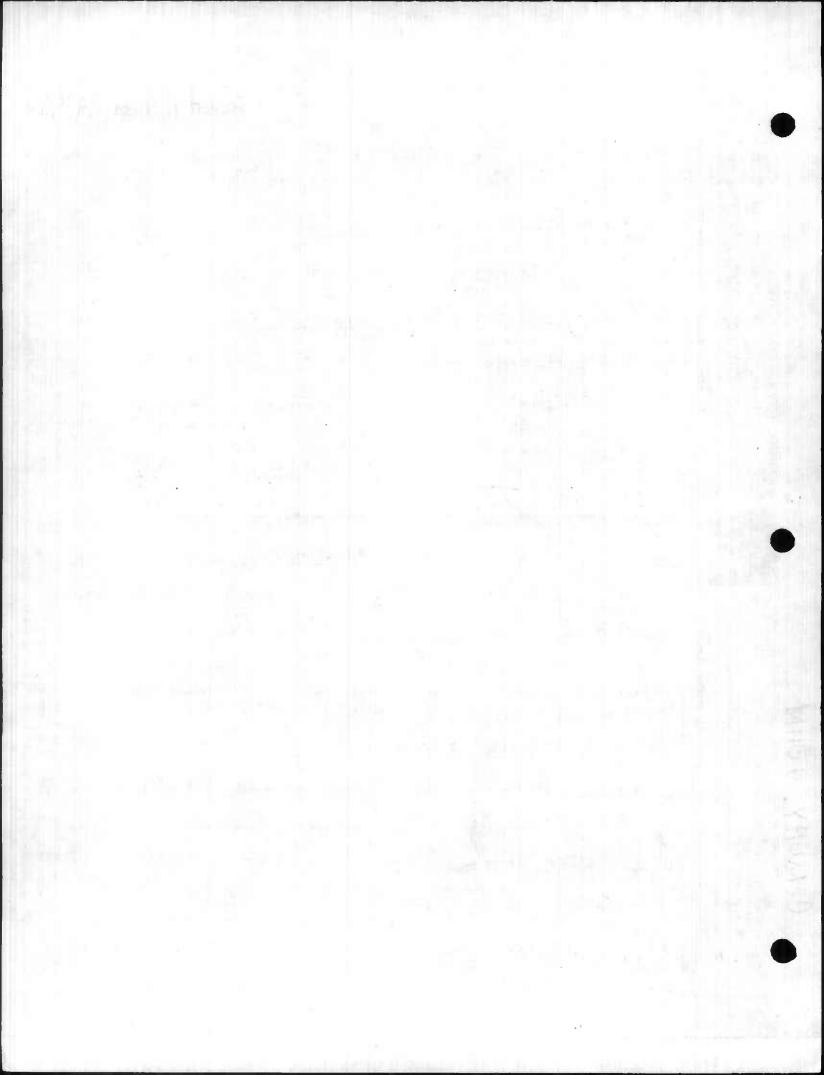
27. Menner of Death 1 Neturel 5 P inv 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Certifier (Check only one) 1 Certifying Phyatclan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D 25027 MD

31. Date tiled (Month, Day, Year)

AUG 1 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

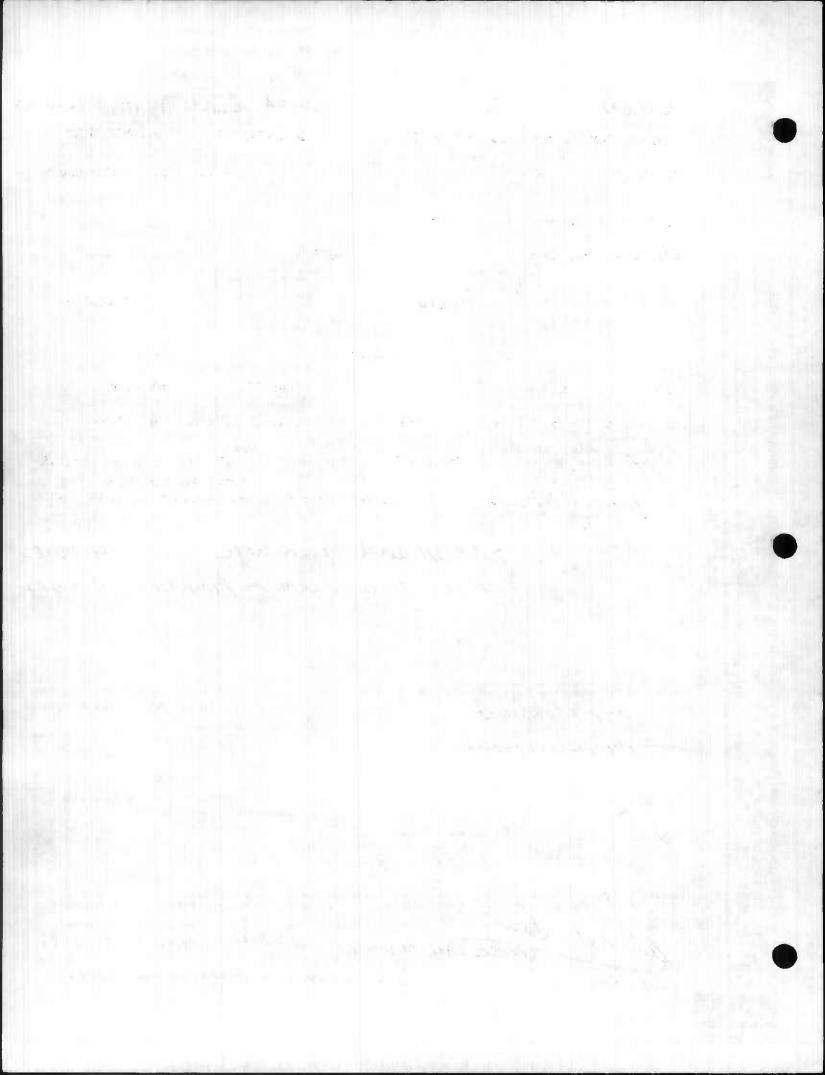
VIJAY M - ABHYANWAR, ZNORTH AVE, BEL AIR MD 21014 32. Registrar's Signature Deneva



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** RUBEN COSCA AUGUST 1210 HRS 1999 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 8. Date of Birth (Month, Day, Year) May 28, 19 If Undar 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) Philippines 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1QM 2□F Months Days Hours Min Yrs. 1937 62 579-62-7909 Director Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 20855 United States 6601 Sweetwater Drive Funeral 12. Was Decedant Evar in U.S. Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Yaar or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. e filed within 72 hours effer all Hygiene.
other than "natural", or ite 1 ☐ Never Married 2 🕅 Married 3altimore, Maryland 21215-0020 1 Ves 2 No Specify Specify: Filipino g 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) 5+ Physician Medical 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be f Department of Health end Mental I Important: If Item 27 Is marked of any Injury or other traumatic eve Anatolia Colmenar Ulpiano Cosca 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20855 6601 Sweetwater Drive, Derwood, MD Patricia A. Cosca, Aug 12, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donator 5 ☐ Other (Specify) Metropolitan Crematory 1999 Alexandria, Virginia ineral Service Licensee 21. Signature of 22. Name and Addrass of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877 Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Subarachuoid hemorhage /Medical immediate Cause (Finel disaasa or condition resulting in death) Examiner Due to (or es e consequence of):
TURE OF INTRA CRANIAL ANURYSM Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last Due to (or as a consequenca of) P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed HYPER UPIDEMIA peen 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) Certification: 5 Pending Investigation Netural death. 1 Yes 2 No 2 Accident or Attend efter death Director: / 6 Could not ba determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours e
 Funeral C Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Within 2 To the woow 29d. Date signed (Month, Dey, Year) 29b. Signatura and titia of certific 29c. Licensa number D 30112 Augus7 THUCK CARO MEDICENECS 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 7100 Deer horsing Ct. Better Da un 20877 DIRENDRA

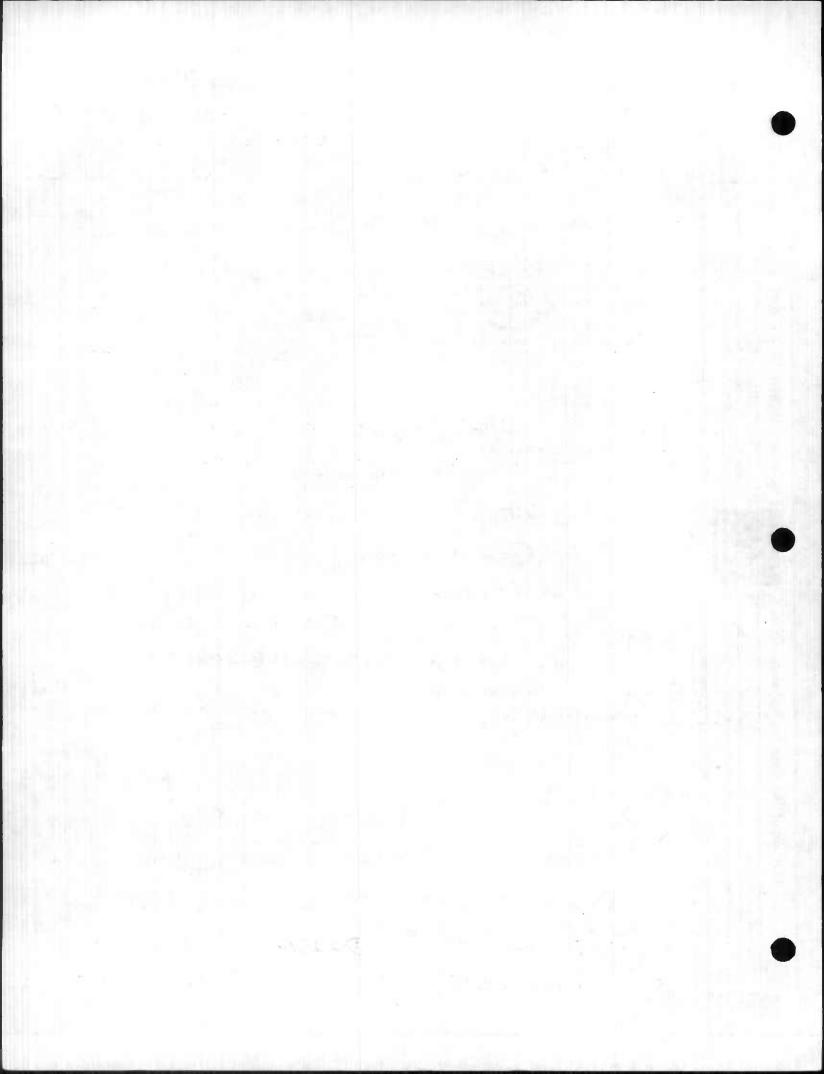
State Registrar



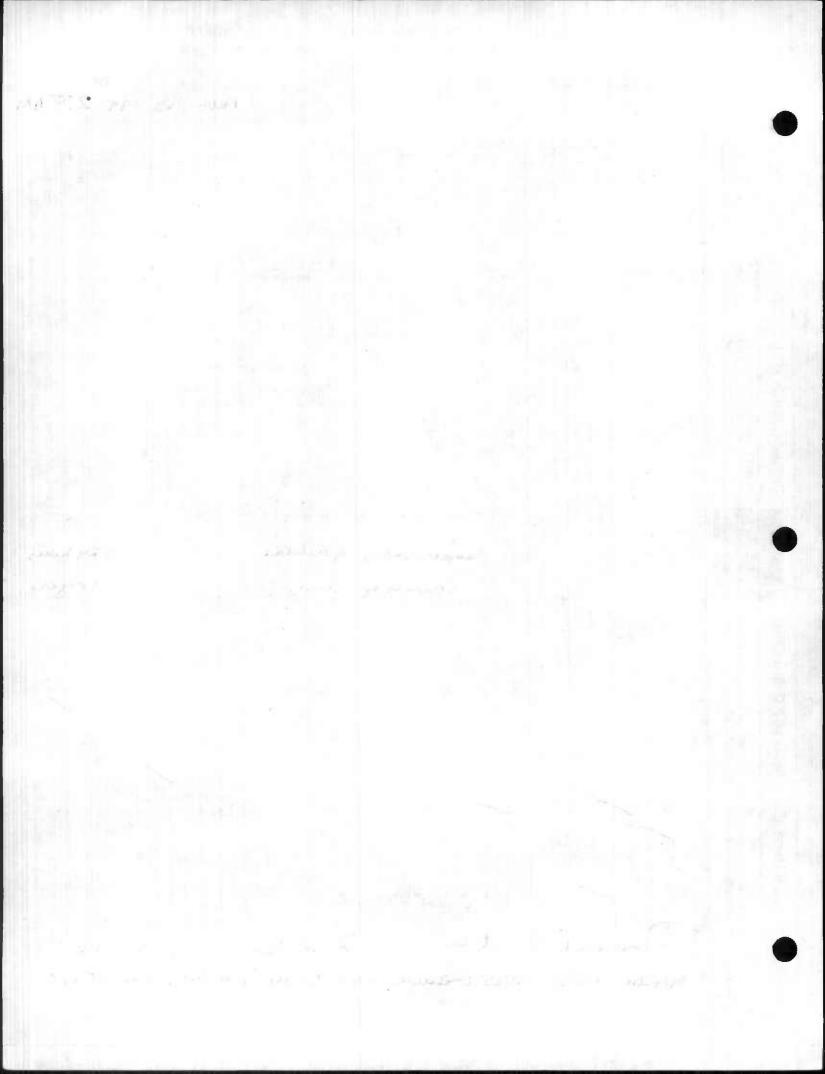
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						Ce	rtificate	e of	Death			Reg. No.		-	0 0
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	Physicia /Medic		Joseph W. Cott	er, III							August			11:	38 PM
	Examine		4a Facility Name (If not institution, gi)			7	4b. City, To	wn, or Lo	cation of Death	4c. Co	unty of Deat		
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Г	Funeral			Sex 7. Ag 1 ☑ M 2 ☐ F	ga (In yrs. la		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Birt (Month, Da	th y, Year)	9. Birt!	hplaca (Stet	a or Foraign
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	Or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	untry?	
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	ner des Nems Iner m	Funeral	11. Marital Status	12. Was Decedent Armed Forcas?		. 13.	Was Deced	lent of h	lispanic Ori an, Mexicar	igin? (Spe	cify Yes or No Rican, etc.)	- 14.	Race - Amai Black, White		
Maryland 21215-0020	ora s	ď	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☑ If Yes, Giva Year or Datas:	No		1□ Yes 2						ecity:	nite	
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Baltimore,	Pages nent of l ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3		COL	metary, cre	matory or o	ther pla	ce)	1					
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	g Physical distribution		27. Manner of Death	28a. Date of Inju	Jry Year) 2	28b. Time o	1 2	8c. tnju	ry at		28d. Describe	how injury o	ccurred		
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	ithin water	-	29b. Signature and title of certifier	and marries st	atoo.		290	. Licens	se number			29d. Date s	igned (Mont	th, Day, Year	r)
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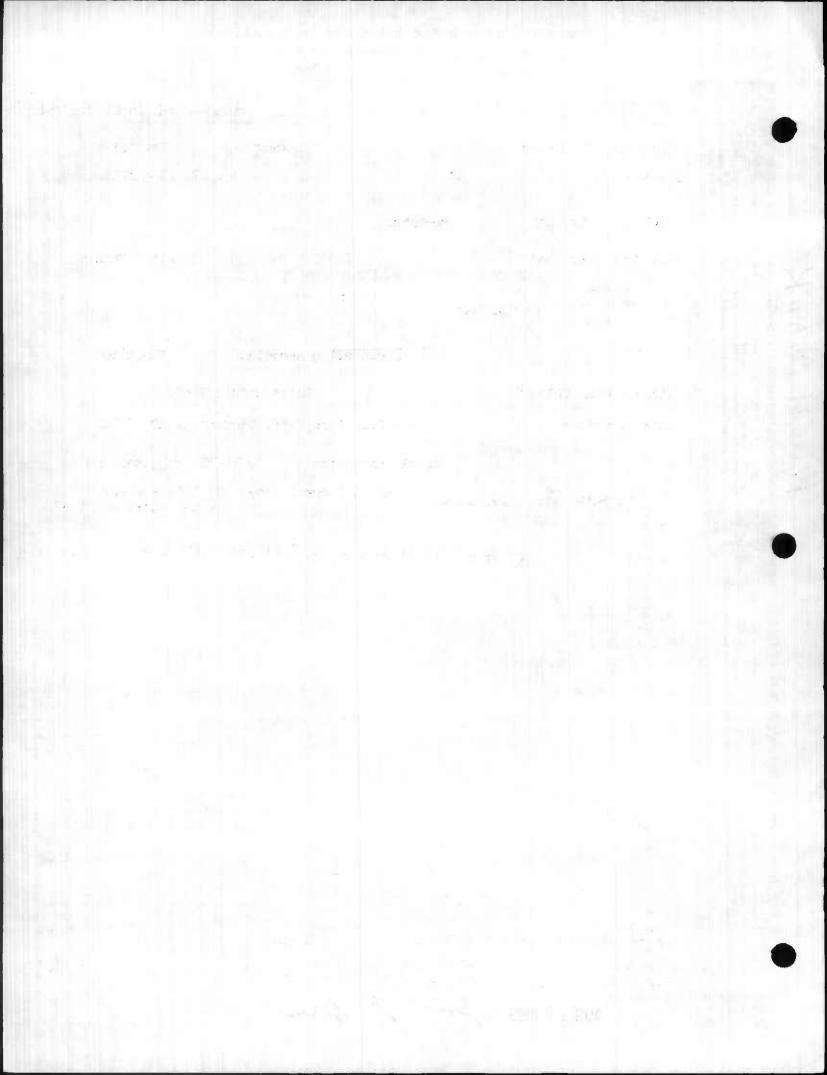
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	ysician: The iav		25. Was case referred to medical exeminer?				26. Place of Deeti	h (Check only o	ne)			
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical Examiner Funeral irrector	1. Decedent's Neme (First, Middle, L RONALD GEORG 4e Fecllity Neme (If not institution, g 2229 Deer Park 5. Sociel Security Number 6.	E CALNEK				AUGUST	Dey Year	6:12 pm	
Examiner Funeral irector	4e Feclity Neme (If not institution, g						19 1771	100	
ineral rector	2229 Deer Park				4b. City, Town, or Loc	ation of Deeth	4c. County of Deeth		
ector	5. Sociel Security Number 6.								
ector		Road Sex 7. Ag	e (In yrs. lest birthda)	y) If Under 1 Year			Carroll 9. Birthi	plece (Stete or Foreign	
W .	338-28-7401	1 ⅓ M 2□ F	64 Yrs.	Months Deys			(Month, Day, Year) Country)		
10 P	Usuel Residence of Decedent		04			lug. Z/	1227 11111	11013	
1 5	10e. Stete 10b. County		10c. City, Town or	Location				10d. Insida City Limits	
1 2	Maryland Carre	011	Finksbu	ıra				1 Yes 2 No	
Director	10e. Street end Number			101. Zip Code		10g. (Citizen of What Cou		
	2229 Deer Park Re	റാർ		2104	10	Th	nited Sta	tos	
Funeral	11. Maritel Status	12. Wes Decedent	Ever In U,S. 13		Hispenic Origin? (Spec pen, Mexican, Puerto F		14. Rece - Ameri	can indien,	
2	1 Never Married 2 Married	Armed Forces? 1 17 Yes 2 1	No			tican, etc.)	Bleck, White,	, etc.	
Ď.	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: Whi	to	
Completed	15. Decedent's I	Education	16a. Dec	edant's Usuel Occu	petion during most of workingd)	16b.	Kind of Business/In		
eld	(Specify only highest g Elamantary/Secondary (0-12)	Collega (1-4or t	(Gr. life.	DO NOT use retire	ed)	9			
TO.	12			Engineerin	ng Associat	ce	Electric		
Bec	17. Fether's Neme (First, Middle, Las	10)			18. Mother's Neme		lan Sumeme)		
ToB	Sidney Dayne Ca	l nek			Helen Hed	dwig Wend	t.		
-	19e. Informant's Neme/Relationship		19b. Ma	lling Address (Stree	t end Number or Rural			ip Code)	
	Linda R. Calnek	wife	2229	Deer Pai	k Road, F	inksburg.	MD 2104	8	
	20e. Method of Disposition		20b. Place of Dis	position (Nema of rematory or other ple			Location - City or T		
	1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Spec	Removel from State			1	/16/00 11-	mactaca	MD	
	21. Signature of Funeral-Service Lice			Crematic 22. Name end Addr		10/99 Hai	mpstead,	MD CIM	
g		1			neral Home	91 Wil	lis Stree	et	
	James C	1. Jeh							
	23a Pari 1. Enter the disease, or conshock, or heert failure. List only	nplications thet caused y one cause on aach li	ne.	enter the mode of dy	ing, such es cardiac o	r respiretory arrast,		Intervel Between Onset end Deeth	
an	Secretary Course (Elect	0		1	() 1 1 1	1 1 70	= 0		
al er	immediate Cause (Final disease or condition resulting in deeth)	. (AK	CINOM	AOF	GALLB	SCKON	614	3 MOOKY	
	resulting in deetily		Due to (or es a cons	sequenca of):					
Examiner		ı b							
X	Sequentially list conditions,		Due to (or as e cons	equance of):					
	Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaasa or injury that initieted avents	c							
edicai	thet initieted avents resulting in death) Lest	-	Due to (or es e cons	equence of):					
_		l d							
by Physician/M									
sic	Pert II. Other eignificant conditions	contributing to death b	out not resulting in the	undarlying causa g	ivan In Part I.	23b. Dld tobac	co use contribute	to the cause of death?	
Phy						1 🗆 Yee	219 No 3 □ Pro	obably 4 Unknown	
by									
Completed						24e. Wes en eu performed	? 8	Vere autopsy findings veilable prior to	
pie								ompletion of cause f death?	
Eo						1 ☐ Yes	20No 1	☐Yas 2☐ No	
Be C	25. Wes case rafarred to predical				26. Plece of Deeth				
To B	exeminer?	Hospital:	ent 2 ER/Outpeti	ient 3 DOA	ther: 4 Nursing Hon		6 □Other (Spec	rify)	
1 2	27. Menner of Deeth	28e. Dete of Inju (Month, Da		of 28c. Inju		8d. Describe how li		,,	
Medical Certification: To Be Com	1 Panding 2 Accident S Panding investigeti		y Year) Injury		ork? ☐Yes 2☐No				
fica	3 ☐ Sulcide 6 ☐ Could not	be 28e. Placa of Inj	jury - At home, ferm,	street, factory, office	1 2	8f. Location (Street	t en <i>d Number or Rui</i>	ral Route Number,	
ert	4 Homicide	building, at	c. (Specify)			City or Town, St	tete)		
edical Certification:	29a, Cartifier 1/7 Certifying F	hyeiclan: To the best	of my knowledge de	eth occurred at the t	time, dete end place, a	nd due to the cause	a(s) and manner as	stated.	
dica	(Check only 2 Medical Exi	miner: On the basis of	f axamination and/or	Investigation, In my	opinion, daath occurre	ed et tha time, dete	end plece, and due	to the cause(s)	
ĕ ⊠	29b. Signature end title of certifier	and mainer 30		29c. Licer	nse number	29d.	Date signed (Month	, Day, Year)	
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	30. Neme and addrass of person who	completed cause of	eth (Item 23a) (Typ	e, Print) 700	- A DOOLE R	a WEST	MINSTER	402157	
State	29b. Signature and title of certifier 30. Name and addrass of person who CHITACHE 31. Dete filed (Month, Day, Year) AUG 1	DU NA	Heth (Item 23a) (Typ)	MD. 700	-A POOLE R	a west	MINSTERL	HDQIS7	



Amendment to #18 per FH 8 20 99 MC

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State of Maryland / Department of Health and Mental Hygiene

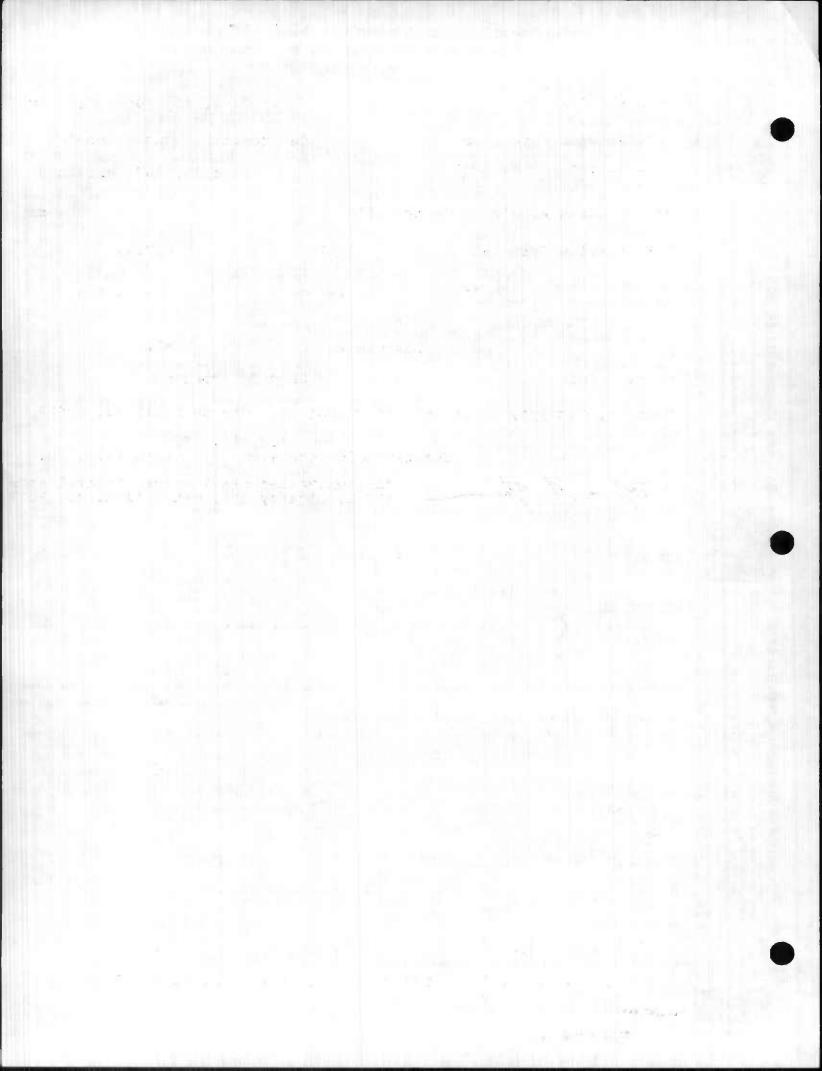
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Certificate of Death	Reg. No

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3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician LOLA MAE COMEGYS 12, 1999 2:30 AM Aug. /Medical 4a Facility Nama (If not institution, giva street and number) GenesisEldercarte City, Town, or Location of Death 4c. County of Death **Examiner** Meredian-Corsica Hills Nursing Center Queen Anne's Centreville If Under 1 Year Months Days If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 10M 35F 220-46-3791 89 Director Sept. 28, 1909 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at Md. Queen Anne's 1 Yes 25 100 Centreville Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 141 Fairview Farm Lane 21617 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after opportunent of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or ites any injury or other traumatic event, the Medical Examina 1 Yes 2 140 If Yes, Give Year or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ to Specify: Specify: White h ₩ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Self 8 18. Mother's Name (First, Middle, Maiden Sumama)
Mary Wax Morgan 17. Fathar's Name (First, Middle, Last) Be Henry Godwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Henry F. Comegys, Sr., (Son) 214 Walnut St., Church Hill, Md. 21623 30c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Aug. 1 urial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cemetery Centreville, Md. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St, Centreville, Md. 2161 23a. Part1. Entar the diseasa, or complications that ceused the death. Do not enter tha mode of dying, such as cardiec or respiratory errest, ehock, or heart feilure. List only one ceuse on each line. Approximete Interval Batween Onset and Death **Physician** /Medical Immediete Ceuse (Finel Cereliourscular occident disease or condition resulting in death) Examiner Examiner wersion the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): that the death certificate be execu physician Box 68760 arte are Physician/Medical Dua to (or as a consequence of): SE 9SI signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown gener by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peed page 2 has 3KN0 1 Tyes 1 ☐ Yes 2 ☐ No certificate Attending Physician: Be 25. Was cese referred to medical 26. Piace of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending invastigation 1 Natural ne Hospital or Attending in 24 hours after death. he Funeral Director: Aft 1 ☐ Yes 2 ☐ No ∠ □ Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 T Homicide 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) 29a, Certifier Medical To the Vithin 2 and manner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Hoey, M.D.; 2540Centreville Rd., Centreville, Md. 21617

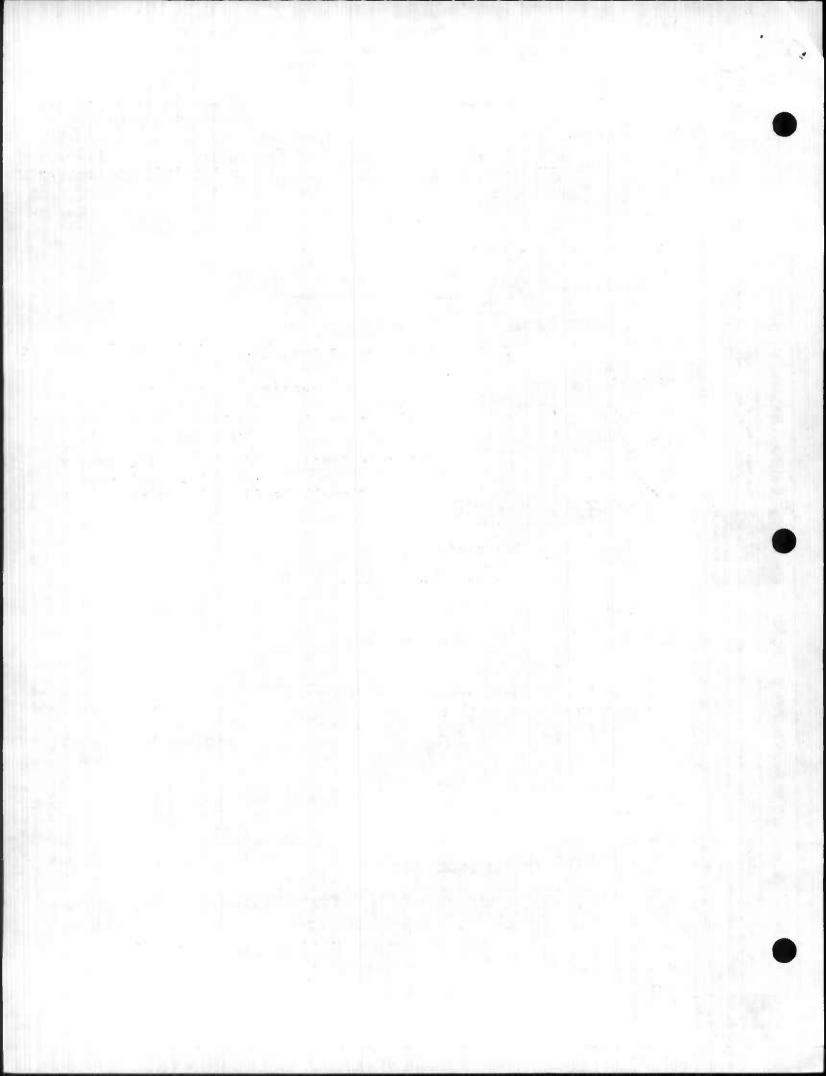
State Registrar 31. Date filed (Month, Day, Year) 1999 32. Register 1999 AUG 19 AUG 2 1 150

32. Registrar's Signature



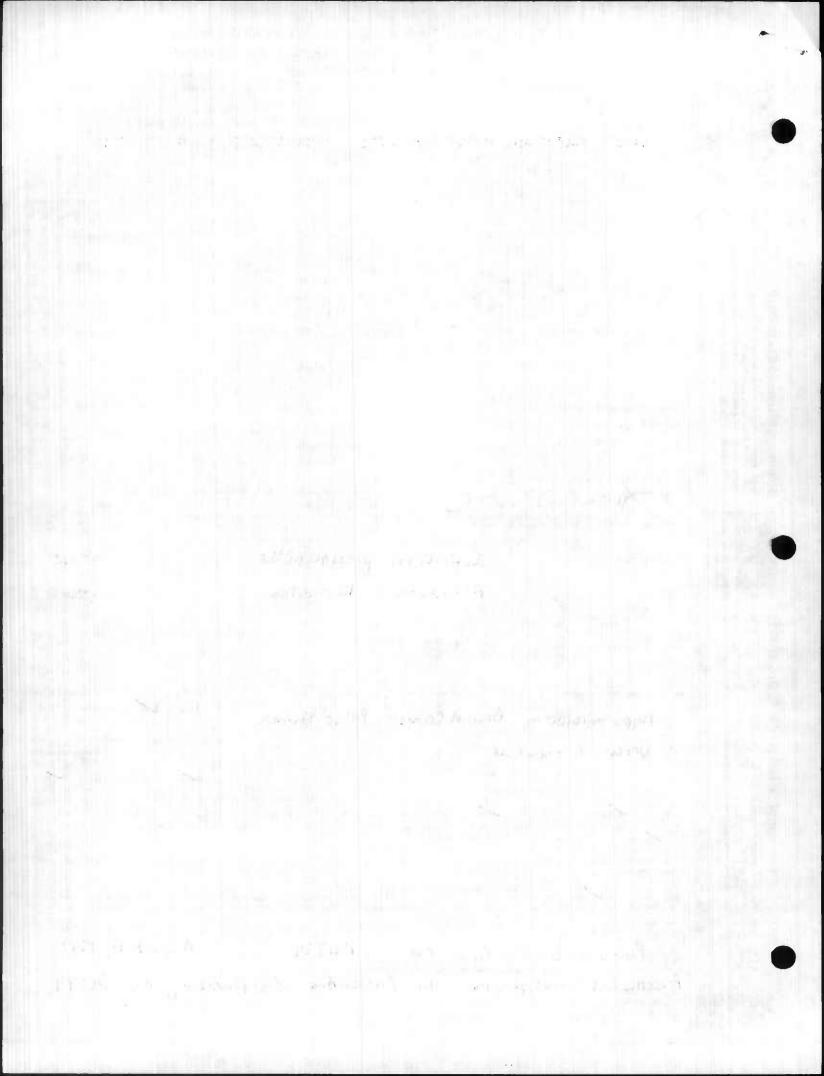
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Milton Doberman August 12,1999 7:25pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4977 Battery Lane Apt#905 Rethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (fn yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months 061-01-6904 86 Yrs. Director April 4,1913 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 le marked other than "natural", or frama 23a or 28a-f show treumatic event, tha Medical Examinar must be notified at HE Yes 2 No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4977 Battery Lane Apt# 905 2 Q814 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? ↑☐ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours efter of the hygiene. 1 Never Married 2 Married Specify: White Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Financial Securities permit. Pages 1 and 2 should be filled will Department of Heelth and Mental Hyglen, important: if item 27 is marked other the eny filury or other treumadic event, that phose. Director of Training 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Doberman Bessie Lottenberg 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Faye Doberman/ Wife 4977 Battery Lane Apt#905 Bethesda MD 20814 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vetern's Cemetery 8/18/99 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham MD 21. Signature of Funeral Service Coense 22. Name and Address of Facility Takoma Funeral Home 254 Carroll St NW Washington DC 20012 23a. Part 1. Enter the disease, or complications that can ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause or cardiac line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia 3 days Examiner Parkinson's Disease Examiner years physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 5 Congestive Heart Failure 2 1 Yes 20Mo 3 Probably 4 Unknown signed bedet Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peeu 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate al or Attending Physicien: T s efter desth. W Director: After this certificat ed in by the funeral director, p. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa Stresidence 6 Other (Specify) Medical Certification: To 1 Yes 20No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1X Natural investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Discomplants tilled in 29a. Certifier Escritifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of optities 29c. License number 29d. Date signed (Month, Day, Year) D13818 8/16/99 30. Name and address of pursuin who completed cause of death (Item 23a) (Type, Print) Cheyy Chase MD 20817 Ave 5530 Wisconsin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 7 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 2 7 | 7 4 Certificate of Death

				Certifica	ate of	Death		Reg. No.	
	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month		3. Time of De
Physician /Medical	Helen Bea	ittie 1	Daniel				August		
Examiner	4e Fecility Neme (If not institution, giv	e street end number)				4b. City, Town, or	Location of Deat	4c. County of	of Death
	SHADY GROVE	E ADVENT	IST HOS	SPITAL		ROCKVII	LE	MONTGO	OMERY
uneral Director	5. Sociel Security Number 6. S 577-18-0415	Sex 7. Ag	e (In yrs. last bii 84	Yrs. If Un Month	der 1 Year ns Days	If Under 24 Hrs Hours Min	(Month, De	th ly. Year) 21, 1915	9. Birthplece (Stete or F Country) Washington
	Usual Residence of Decedent		10 07 7						101 1 11 00
23a or 28a-f show ust be notified at rai Director	10a. State 10b. County		10c. City, Tow						10d. Inside City 1 ☐ Yes 2
cto diffe	MD Montgome	ry	Mont	gomery		ige			Λ
or 2	10e. Street and Number				Zip Code			10g. Citizen of W	/het Country?
238	9824 Whetstone Dr	ive			20886			USA	
or tems preminer m by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes XXI If Yes, Give Year or Dates:	Ever in U,S.			Hispanic Origin? (Seen, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White
r, the Medical I	15. Decedent's Ed	ducetion	16a	. Decedent's U	sual Occup	pation		16b. Kind of Bu	siness/industry
other traumatic event, the Medical	(Specify only highest gre Elamantery/Secondary (0-12)	ede com <i>pleted)</i> College (1-4or !		(Give kind of lifa. DO NO	work done Tuse retire	pation during most of wo d)	rking		
E O	12	College (1-401 ;)+)	Homema	ker			Own Ho	ome
marked other than imatic event, the M To Be Comp	17. Father's Name (First, Middle, Last))				18. Mother's Na	ma (First, Middle	, Maiden Sumeme	
Be See	James S. Beattie					Helen	Martin		
To To		Total Briefly	101	Madine Asia	ann (Campa			os City os Tourn	State Zin Code)
100	19a. Intorment's Neme/Relationship (198			t end Number or R			
100	Candy D. Howard -	Daughter	1			stone Dr.			lage, MD 208
	20a. Method of Disposition	Demoval from State	20b. Plece o	t Disposition (i	Neme of or other ple	ece)	Date	20c. Location - 0	City or Town, State
Important: If any Injury or once.	4 Donation 5 Other (Specif		Chris	st Chur	ch Ce	emetery	8/14/9	Irving	gton, Virgin
any Injury	21. Signature of Juneral Service Licer). War	R	Me	tropo	ess of Fecility Olitan Fu ne Stree	neral Se	ervice, I	Inc. A 22310
100	23a Part LEnter the disease, or com	plications that caused	the death. Do	not enter the n	node ot dyi	ing, such as cerdia	c or respiratory a	rrest,	Approximata
stcian	shook, dynean tailure. List only	one causa on aach li	ne.						Interval Betwee
edicai	Immediata Ceuse (Final								
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ial-transit Examiner		A	12 Hein	vor, 2	Der	renta			2003 h
s the burial-transit	Sequentially list conditions,		Due to (or es e	consequence	of):				
	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events								1
edical	thet initiated events	C	Due to (or es e	consequence (of):				1
	resulting in death) Last								
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be detached for use by Physician/A							OOL DIA	A-b	
etached for use a Physician/M	Part II. Other significant conditions of	contributing to death b	ut not resulting i	in the underlying	ng cause gi	ven in Part I.			ntribute to the cause of
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b b	The street	,		ı		1			Cab Mara autonou dia
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ge 2 shoul	VG 5. 1 50 K	po. 032							of deeth?
Page							100	Tas 2 No	1 ☐ Yes 2 € N
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nector Be	examiner?	Hospital:			DOA Ot	har			(016.)
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this cal dire	1.27 Manner of Dooth	28e. Date of Inju (Month, De	y Year) 200.	Injury	28c. Inju		200. Dascribe	now injury occurr	100
uneral d	27. Manner of Death 1 ☑Natural 5 ☐ Pending	n		М	1]Yes 2□No			
the funeral d	1 PNatural 5 Pending 2 Accident Investigation		ury - At home for	erm, street, fac	tory, office		28f. Location ((Street and Numbi wn, Stete)	er or Rural Route Numbe
tification: To	1 Natural 5 ☐ Pending	289. Place of Inj	c. (Specify)						
ed in by the funeral d Certification: To	1 Danatural 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be	28e. Place of Injuding, et	c. (Specify)						
yfilled in by the funeral d	1 DNatural 5 Pending Investigation 3 Sulcide 4 Homicide Could not be detarmined	building, et	c. (Specify) ot my knowledg	e, deeth occur	red et the ti	ime, date and plac	e, end due to the	ceuse(s) and ma	anner as stated.
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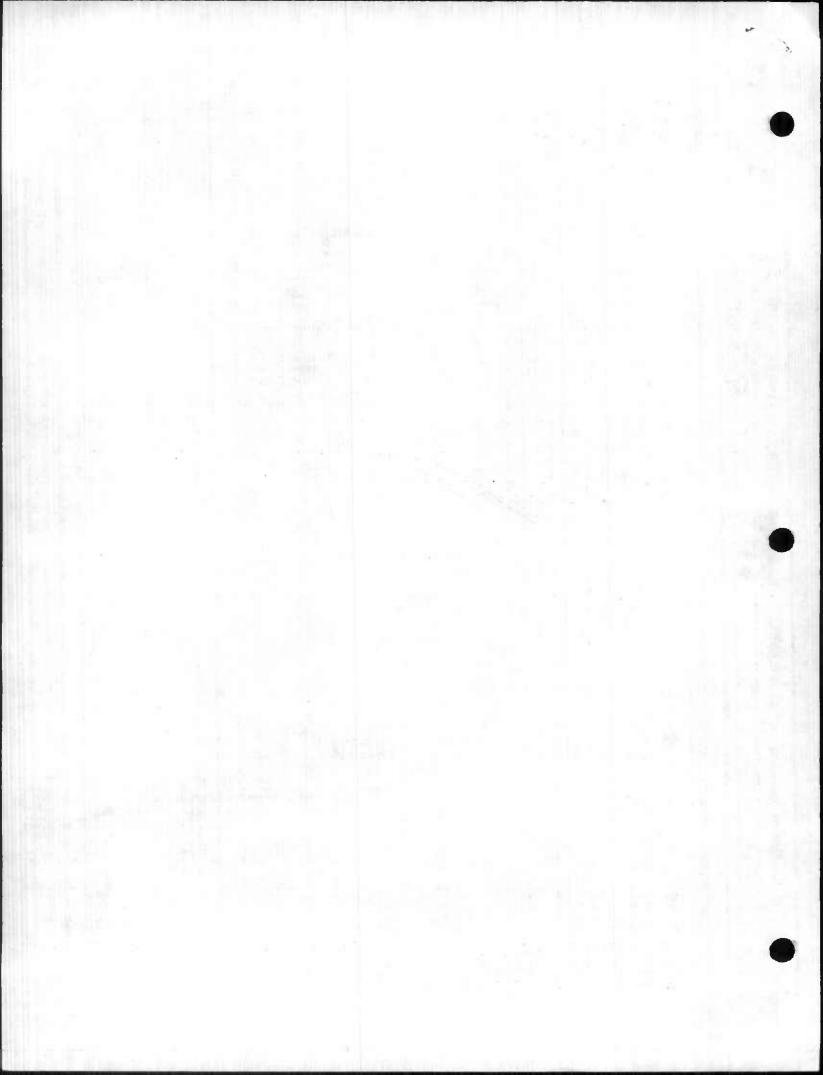


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dey Year **Physician** AUGUST 15, 1999 THI DANG 9:00AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME WHEATON MONTGOMERY 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 10 M 20 F Months Hours Yrs 220-53-4190 68 MAY 5, Director 1931 VIETNAM Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23s or 28s-f show Examiner rest be notified at MD MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No Director 10e Street and Number 10f Zio Code 10g. Citizen of What Country? death with 14302 LAYHILL VALLEY COURT 20906 VIETNAM Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, atc. filed within 72 hours after 1 ☐ Yes 2 ☐No 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☐ No Specify: Specify: ASIAN by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith and Mental Hygiene. 27 is marked other than *r r traumatic avent, pre Med Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be in Department of Heelth and Mental Important: If them 27 is marked of any injury or other traumatic ave QUE VAN DANG VANG THI VO 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) THAI VAN TRINH (SON IN LAW) 14302 LAYHILL VALLEY COURT SILVER SPRING, MD 20906 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State FT. LINCOLN CREMATORY 8-18-99 BRENTWOOD, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signifium of Funeral Service Licenses 22. Name and Address of Facility INES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one-cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical arcinoma many Examiner Due to (or as a consequence of): months Examiner that the death certificate be asscuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence ot): Box 68760. attending physician for use as the buna Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yee 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were eutopsy lindings available prior to Completed 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medicel exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1. Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident hours after deeth 6 Could not be determined To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) · G. auptamo August 16, 1999 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20852 409 lave Crupta 121 congressiona 6 Amistrer's Signeture

Registrar

State

1999



State of Maryland / Department of Health and Mental Hygiene

					(Certifica	ate of	Death		Reg. No.	2 6	. / 1 / 0
П	Physic	ian	Decedent's Nema (First, Middle, La	est)					2. Dete of De Month	eath Day	Year	3. Time of Death
ı	/Medi		Louise Alice						AUGUST		999	06:59 AM
	Exami	ner	4e. Facility Name (If not institution, gir					4b. City, Town, or		h 4c. Count	y of Deeth	
L			MALCOLM GROW MED		R			CAMP SPRI			E GEO	RGE'S
4	Funeral Director			Sax 7. Ag 1□M 2X F	e (In yrs. last birth	Month	der 1 Year ns Days		8. Date of Bir (Month, De Nov. 1	y, Year)	9. Birthp Coun M A	place (State or Foreigntry)
	land m		10a. Stete 10b. County		10c. City, Town	or Location					1	Od. inside City Limits
	with the Meryland a or 28a-f show	ō	VA Drings	17:11:	T) 1. C							1 ☐ Yes 🏖 ☐ No
	the 128s	Director	VA Prince	william	Dale C		Zip Code			10g. Citizen of	What Coun	ntrv?
	3a o		14200 Ferndale R	oad			2193			USA		
	deeth	Funeral	11. Maritai Status	12. Wes Dacedent	Ever In U,S.	13. Was Da	cedent of	Hispenic Origin? (S	pecify Yes or No		ce - Americ	an indian,
21215-0020	72 hours effer deeth with the Meryland "natural", or flems 23a or 28a-f show sdigst Examiner must be notified at	by	1 Never Married 2 Neverled	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes:		if Yes, s	pecify Cul 2/2 No	oen, Mexican, Puert	o Rican, atc.)		ock, Whita, if fy: Whit	
2-0	72 ho	P	15. Decedent's E		16a, E	ecedent's U	suei Occu	pation		16b. Kind of 8		
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		60	12			nemak	er	_		Own Hor	ne	
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Maryland	d 2 should be filed the and Alental Hyg 7 is marked other traumatic event,	2	Horace W Hutchin	gs				Mona Bull	ey			
Jar	2 sh and is m		19a. Intorment's Neme/Reletionship					t end Number or Ru		-		Code)
	CHNP		Joseph Roger Dub	oois				e Road, Da				
altimore,	S to L		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		20b. Plece of Cometery. Quanti				Dete 8-24-99	20c. Location		wn, Stete
alt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Clos	nsee		22. Nema	and Addr	ess ot Fecility				
m	88 1 1 8		1 John C	· Tago				stle Funera e Blvd. Da			2	
			23a. Part 1 Enter the disease, or com		the death. Do no	t enter tha m	ode of dy	Ing, such es cardiec	or respiratory a	rrest,	3	Approximate
	Physician		andox, or deat tellure. List only	one ceuse on each III	ne.						į	interval Between Onsat and Deeth
	/wedicar		Immediate Cause (Final disease or condition	NOM-HOD	GKINS LY	ириом и						0/ 375450
	Examiner		resulting in death)	a. NON-HOD	Due to (or es e co						1	04 YEARS
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Ó	e axe len el	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying									
68760,	eta be	edicai	Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest	c	Due to (or es e co	nsequence o	t):				<u> </u>	
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Box	eath cer attendir I for use	Physician/	_	d								
0	a death the atter hed for u	/sic	Pert il. Other significent conditions o	ontributing to death b	ut not resulting In t	he underlying	g ceuse gi	iven in Pert i.	23b. Did	tobacco use co	ontribute to	the cause of death
<u>o</u> .	thet the dended by the a	Ph	GASTROINTESTINA	HEMORRHA	CF.				10	Yes 2□ No	3 Prot	bebly 4 Unknow
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Record	sw requiras s been sign 2 should be	Completed								an autopsy emed?	COL	ere autopsy tindings eilable prior to mpletion of ceuse death?
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a		Be C	25. Wes cese retarrad to medicei					26. Piece of Dec	eth (Check only o			
>	Physician: The i this certificeta he ral director, page	0	exeminer? 1 ☐ Yes 2 ☐ No	Hospitel: 1 inpatie	nt 2□ER/Outp	etient 3	DOA Ot	hor	lome 5 ☐ Resi		her (Specify	v)
0	Attending Physician: ir death. ector: After this certific by the funeral director,	n: T	27. Makaner ot Deeth	28e. Dete of inju (Month, Da		ne of	28c. inju			how injury occu		
0	ath. r: Aft	atio	1 ☑ Naturei 5 ☐ Pending 2 ☐ Accident investigatio		<i>Year)</i> inj	M		Yes 2 No				
Division of Vital	Die at o	Certification:	3 Suicide 6 Could not be determined		ury - At home, tam c. (Specify)	n, street, tact	ory, office	2!	28f. Location (: City or To	Street and Num. wn, Stete)	ber or Rure	l Route Number,
	To the Hospital 24 hours To be Funeral completely filled	edical (29e. Certifier (Check only one) 1 Certifying Ph	ysician: To the best on ninar: On the basis of end menner ste	examinetion end/	deeth occurre or investigati	ed et the ti	me, dete end piece opinion, deeth occu	, end due to the rred at the time,	cause(s) end m dete end place,	enner as st and due to	eted. the cause(s)
	the design	Me	29b. Signeture end title ot certitier			2	9c. Licen	se number		29d. Dete signe	ed (Month, I	Day, Year)
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	Ya		30 Name and address at name in	company year	eath /Itam 02=1 /*	una Priett					-	, , , , ,
	00		30. Name and address of person who					OG/ 1050 T			20762	((00
	C		KELSON M. FIGAS 31. Dete tiled (Month, Day, Yeer)		oAFK, MC	-	HNUKE	EWS AIR FO	JKCE BAS	E, MD	20/62	-6600
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State of Maryland / Department of Hea Certificate of De

Ith and Mental Hygiene 99 27 77	ath	Reg. No.	400		No.		0	6	_
	Ith and	Mental Hygiene	9	9	2	7		7	7

29d. Date signed (Month, Day, Year)

august

Physici /Medic Examin	a
Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or flams 23a or 28a-f showny injury or other traumatic svent, the Medical Expenses pages. þ **Physician** /Medical Examiner Physician/Medical Examiner attending physician and for use as the burial-transit Box 68760, requires that the death certificate be P.O. 1 signed by I Division of Vital Records, by Completed certificate has Hospital or Attending Physician: Be 10 this funeral Certification: s after death. within 24 hours a To the Funeral D completely filled 29a. Certifier Medical (Check only one) To the 29b. Signature and title of condifier my 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Saturnina T. Chang M.D. 10701 New George's Creek SW Frostburg MD 21532 Saturnina T.

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug 19, 1999 Dolly Eleanor 11:50am Catherine 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Goodwill Mennonite Nursing Home Grantsville Garrett Months Days Hours Min. 8. Date of Birth Mar 1915 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 213-64-9896 1 M 25 F 84 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🌪 ☐ No Allegany Cumberland 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Route 4 Box 176 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcesty 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes val No Specify: Specify: white Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Meiden Sumeme) Edith James Henry Myers (Link) 19a. Informent's Name/Reletionship (Type, Print)

James H. Dolly 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 800 Nemacolin Avenue; Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 Donetion 5 Other (Specify) Davis Memorial Cemeter8/23/ Cumberland, MD 21. Signature of Funeral Servica Licansee 25 Carper 1 Funeral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete tnterval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Pneumonia Due to (or as e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? PARKinson's DiseasE Basal Cell CARcinema of The Scalp. 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Whursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 26b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 261. Location (Street and Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year)

AUG 2 0 1999

32. Registrar's Signature

Loude

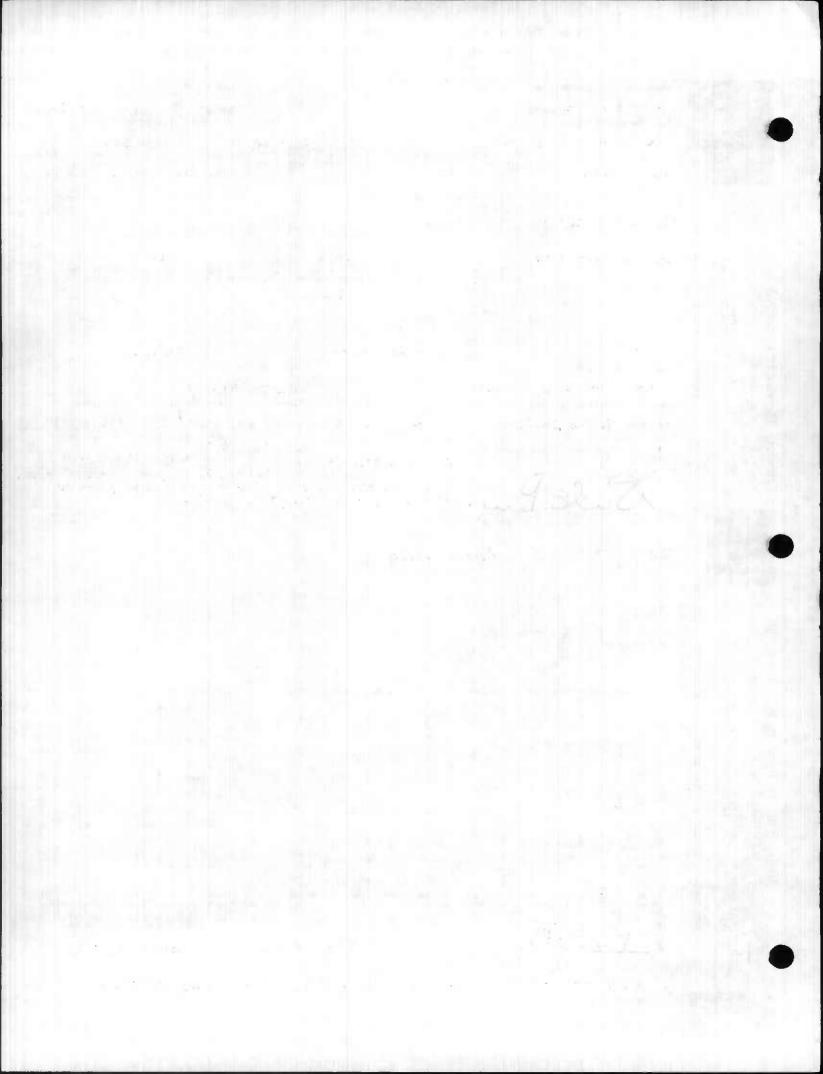
29c. License number

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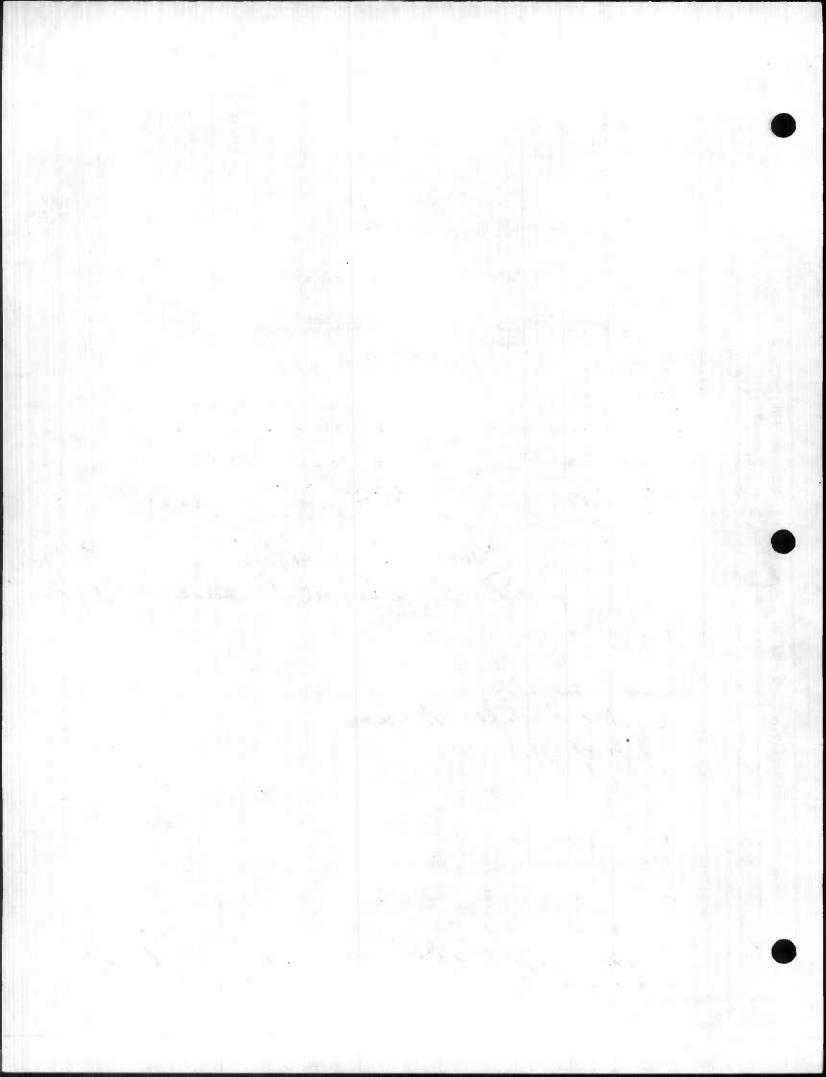
State of Maryland / Department of Heal	Ith and Mental Hygiene	

							Ce	rtificate		Death		Reg. No.	6.	1110	
Physici		an	1. Decedent's Name (Fi	rst, Middle, Las	51)						2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		Martha C	. Doug1	as						August	13, 199	17.27.0	6:20PM	
	Examin		4a Facility Nama (If not	institution, give	e street and number	r)			4t	. City, Town, or Lo	ocation of Deat	4c. County	of Death		
			Maplewoo.	d Park	Place					Bethesda	1	Mont	gomer	У	
	Funeral		5. Social Security Numb			ge (In yrs. I		If Under 1 Months	Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthple	ace (State or Foreign	
	Director		330-14-948	80	□ M 2/QXF	96	Yrs.					21, 1902	N. I	reland	
	and *	1	Usual Residence of Dec 10a. State 10t	o. County		10c. City	, Town or L	ocation					10	d. Inside City Limits	
	aho	5											1.0	1 ☐ Yes 2X No	
	28a-I	Funeral Director	Maryland Mo		ry	Beth	esda	104 7:- 0	anda.			10a. Citizen of V	After Count	n./2	
	No a	급						10f. Zip C							
Maryland 21215-0020 d 2 should be filed within 72 hours effer death with the Maryland th and Mental Hygiene. 7 is marked other than "naturel", or itema 23a or 28a-f ahow traumatic event, the Medical Exercities must be notified at		a la	9707 Old G	eorgeto	wn Road,		0 40		814	mania Orining (Co	- sib. Ves es Ale	United	State e - America		
	iten de	S	11. Maritel Stetus 1 Never Married	O Atomical	Armed Forces	?	5. 13.	If Yes, specify	y Cuber	panic Origin? (Sp , Mexican, Puerto	Rican, etc.)	Bled	ck, White, e		
2	rs of	by F	3 ☐ Widowed 4 ☐		If Yes, Give			1 □ Yes 2	No No	Specify:		Specify	Whit	te	
3	hou	8		Decedant's Ed			16a Dec	edent's Usual (Occupa	tion		16b. Kind of Bu			
2	in 72	Set	(Specify o	n <i>ly highest gr</i> a	de completed)		(Giv	e kind of work DO NOT use	done du retired)	ring most of work	ing				
0200-61212	iene.	EO	Elemantary/Secondar	y (0-12)	Collega (1-4or	(5+)	Se	cretar	У			Privat	e		
0	Hyg other	To Be Completed	17. Father's Name (First	t, Middle, Last)						18. Mother's Nam	e (First, Middle	Maiden Surnam	10)		
2	lenta ked ked ic ev	0 8	James Al	exander	Douglas					Margaret	Sloan				
Maryland	should be tand Mental I	-	19a. Informant's Name/	Relationship (7	Type, Print)		19b. Mai	ling Addrass (Street a	nd Number or Rur		er, City or Town,	Stata, Zip (Code)	
	and 2 baith a n 27 is		Michael W.	Dougla	S Nenhew		4911	Bald	Hill	L Road, A	Adamsto	wn. Marv	land	21710	
ā,	-155	-	20e. Method of Dispositi	ion		20b. P	lace of Disp	osition (Name	of place	Aug. 16	Date	20c. Location -		vn, Stata	
Ê			1 X Burial 2 □ Cr 4 □ Donation 5 □			B	1-1	M	- 1	Aug. 16	, 1999	Rockwi 1	10 M	faryland	
Baltimore,	permit. Page Department of Important: If any injury or once.	-	21. Signature of Pagera			Pai	KLawi	Memor	Address	of Fecility Rol	pert A.			eral Home	
n	Dep		1	00	D		F	lockvil	1e,	Inc. 30	00 West	Montgon	ery A	venue	
_		-		الكرك.	Jany	. MOC)803 F	lockvil	1e,	Maryland	2085	0-2805		Approximate	
			23a. Part1. Enter the di shock, or haart fai	lure. List only	one cause on each	line.	i. Do not ei	iter the mode	or dying	, such as cardiac	or respiratory a	rrest,		Intarval Between Onset and Deeth	
	Physician /Medical		Immediata Causa (Fina		0										
	Examiner	1	disease or condition resulting in death)		aPn	eum	onic	1							
		P.				Due to (o	as a conse	equence of):							
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	al-tra	Xa	Sequentially list condition if any, leading to immediate. Enter Underlying	tially list conditions, and to (or as a consequence and to immediate					uence of):				1		
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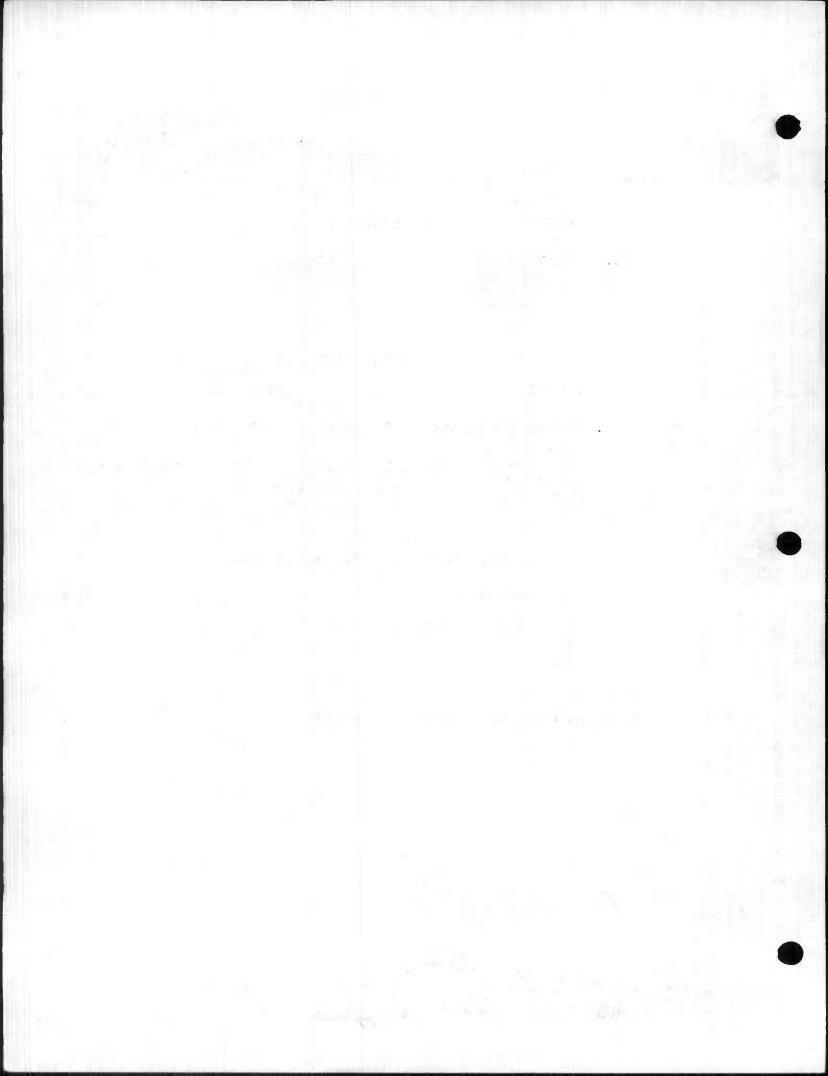
State of Maryland / Department of Health and Mental Hygiene

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W THE	Maryland Montgom	ery	Silver Spring	3			1 ☐ Yas 2 ☐ No
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er tr	Jonathan C. Duffi	e (son)	13224 Chestnu	ut Oak Driv	e Gai	thersburg, M	aryland
permit. Peges 1 and Department of Health Important: if them 27 and Injury or other them 27 and Injury or other them 27 and 15 an	20a. Method of Disposition		Plece of Disposition (Nema of cematary, crematory or other)	place)	Data	20c. Location - City or 1	Town, Stata
7 Ft. Ft	t 🖾 Burial 2 🗆 Cremation 3 🗆 F		e of Heaven Co		/10/005	ilver Sprin	a Maryland
mit. Partmy Vinjur	21. Signature of Funeral Service Licens	pac	22. Name and Ad		0/13/330.	livel Spili	ig, mary rand
	NO V CVA	-		J. Collins	Funeral	Home, Inc.	
)	J. Ten Stille		500 Unive	ersity Blvd	.,W.,Si	lver Spring	
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de-	ath. Do not entar tha moda of	dying, such as cardiac	or raspiratory arra	est,	Approximata Interval Between
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Examiner	resulting in death)	a. (77700)	myruca	- Aller			200195
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E 60 E	Part If. Other significant conditions co			given in Part I.			
that the death certified by the ettending a deteched for use a Vertician AV	Part II. Other significant conditions co			given in Part I.	23b. Did to		
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				Certificate of I			Reg. No.	2.1100
	Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day	3. Time of Death
	/Medi		Clark M. Davis			- 8	1.0	99 615 AM
	Exami	ner	4a. Facility Name (If not institution, give streat and number)	4	b. City, Town, or Lo		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
_		ш	5. Sociai Security Number 6. Sex 7. Aga (In yrs. 14	ast birthday) If Under 1 Year	Westway If Undar 24 Hrs.	Noten	Cur	
8	Funeral Director		5. Social Security Number 6. Sex 1 2 M 2 F 7. Aga (In yrs. In 2 Security Number 1	Yrs. Months Days	Hours Min.	8. Date of Birtl (Month, De) May 9		Birthplace (State or Foreign Country) G A
	hours after death with the Maryland ural; or items 23a or 28a-f show all Examiner must be notified at			, Town or Location				10d. Inside City Limits
	Se-f	ct		estminster				1 √Yes 2 No
	ith th	Director	10e. Street and Number	10f. Zip Code			log. Citizen of W	het Country?
	ath v	- La	205 St. Mark Way		158		USA	
	Hem Hem	Funeral	11. Maritai Status 12. Was Decedent Evar in U,S Armed Forces?	 13. Was Decedent of His if Yas, specify Cuba 	ispanic Origin? (Spe in, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race Black	- American Indian, c, Whita, atc.
20	s aft	by F	1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1□ Yes 2□ No	Specify:		Specify:	White
8	hou		15. Decedent's Education	16a. Decedent's Usual Occupa	etion		16b. Kind of Bus	
21215-0020	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of workli	ng	TOD. KING OF BUS	and a moustry
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g	e filed al Hygie other vent, II	Be	17. Father's Nama (First, Middle, Last)		18. Mother's Name	(First, Middle,		
Maryland	should be t and Mental I marked of umatic eve	To	Edward Hunt Davis		Hester	Kell		
a	C) (0 er =		19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street of	end Number or Rura	l Route Numbe	r, City or Town, S	State, Zip Code)
	Health am 27 other tr		Frances D. Pollard/daughter		r Rd Gl	yndon	MD 21	071
Ore	it of H If Iten or oth		20a. Method of Disposition \$□ Buriai 2 □ Cremation 3 □ Removal from State 20b. Place	ace of Disposition (Neme of metery, cremetory or other plec	e)	Date	20c. Location - 0	City or Town, State
Ē	nit. Pagartmen ortant: Injury		4 Donation 5 Other (Specify)	Hill Cemet		21/99	Griffi	n, GA
Baltimore,	permit. Pages 1 an Department of Heat Important: If Item 2 any Injury or other once.		21. Signalate of Juneral Service Licenson	22. Name and Address	an amal II	[Omo 01	nd Chor	nal .
_	7D = 8 0		K. St	412 Wash	ington R	d West	tminste	r. MD 21157
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	ecute and trans	Cam	Sequentially list conditions,	as a consequence of):				
60,	clan a	E	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury	tun				3 clers
68760,	ificate be executed g physician and as the bunal-transit	edical Examiner	that initiated avents	as a consequence of):				3
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<u>α</u>		by PI	Parterneurs Moeure, M	uped Demen	stra	101	es 2000	3 Probably 4 Unknown
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Rec	8 8 6	mp						of deeth?
=	certificate h		OF Minarcon of control of the last			1 Y		1 Yes 2 No
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	두 두 교	-	27. Manner of Death 28a. Date of Injury	28b. Time of Injury Work			ow injury occurre	1-7
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\overline{a}	or Attending after death. Director: After d in by the fune	Certification:	2 Could not be	ne, farm, street, factory, office	2	28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Phyalctan: Te the best of my frow and deficit Examiner: On the basis of examination and manner stays.	riedge death ookyyed et the tim on and/or investigation, in my or	ne, date end plece, e pinion, death occurre	end due to the co	ause(s) and mer date and place, a	nnar as stated. nd due to the cause(s)
	Vithir Vomp	Me	29b. Signature and title of certifier	29c. Licanse	a numbar		29d. Data signad	(Month, Day, Year)
) Alaman	V1 02	7949		Aug. 1	6th 1999
,			30. Name and address of parson who completed pause of death (Item	23e) (Type, Print)			2,	- , (
			Alexander Bourdascheurston u	o 205 St. Me	we we	y (We)	semme	behlaaa
	Sta		31. Date filed (Month, Dey, Year) 32. Registran Signatu	ure 4	1. ()		



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month August DOL 7:50 1999 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HE JOHNS Hopkins BALtimore HOSPITAL 8. Date of Birth (Month, Day, Year) CITY If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 100M 20 F Months Deys Hours Min. Unknown Usuel Residenca of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10500 2062 tone HVenue . Wes Decedent Evar in U,S. Armed Forces? 1 Yas 2 No If Yes, Give Yaer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - Amarican Indian, Bleck, White, atc. 11. Marital Status 12 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) NA NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Unknown Davis 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Aural Routa Number, City or Town, Stete, Zip Code) Cheltenham MD. Ote, 20c. Location - City of Town, State Blackstone IVe Ave-10500 MD. 20623 Davis-mother 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 1 Burial 2 Community 4 Donation 5 Dother (Specify) DIS posa opkins Hospital Baltimore, Md. 21287 21. Signature of Funerel Service Los . Wolfe **>HH-**N MINOS 600 Part. Enfer the disaasa, or complications thet caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart feiture. List only one cause on each line. Approximate Interval Batween Onset and Deeth Immediate Cause (Fine) ore un diseese or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 W No 1 🗆 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred

Examiner The law requires that the death certificate be executed Box 68760. Physician/Medical for usa P.O. Division of Vital Records, Be Completed by page 2 certificate has or Attanding Physician: funeral director, edical Certification: To this After death. within 24 hours after deatl To the Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

x 28a-f show a notified at

from 23a or 2 from mast be n death with

"natural", or item solical Examiner

Peges 1 and 2 should be filed within 72 hours after or neal of Heelin and Mental Hygiene. ntt: filem 27 is marked other than "natural", or fles iny or other traumatic avent, the Mentice Empire iny or other traumatic avent, the Mentice Empire

Department of Important: If any Injury or

Physician Лиедіса

Examine

Baltimore, Maryland 21215-0020

Director

Completed by Funeral

Be

the Marylend

25. Was casa reterred to medical examiner? 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28t. Location (Street end Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. 29b. Signeture and title of certities 29c. License number 29d. Dete signed (Month, Day, Year)

es-000

MOSFITHZ

2/17/99

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRANDON BNKOWSKI MD JOHNS HOPKING

31. Date filed (Month, Dey, Year)

AUG 8 0 1999

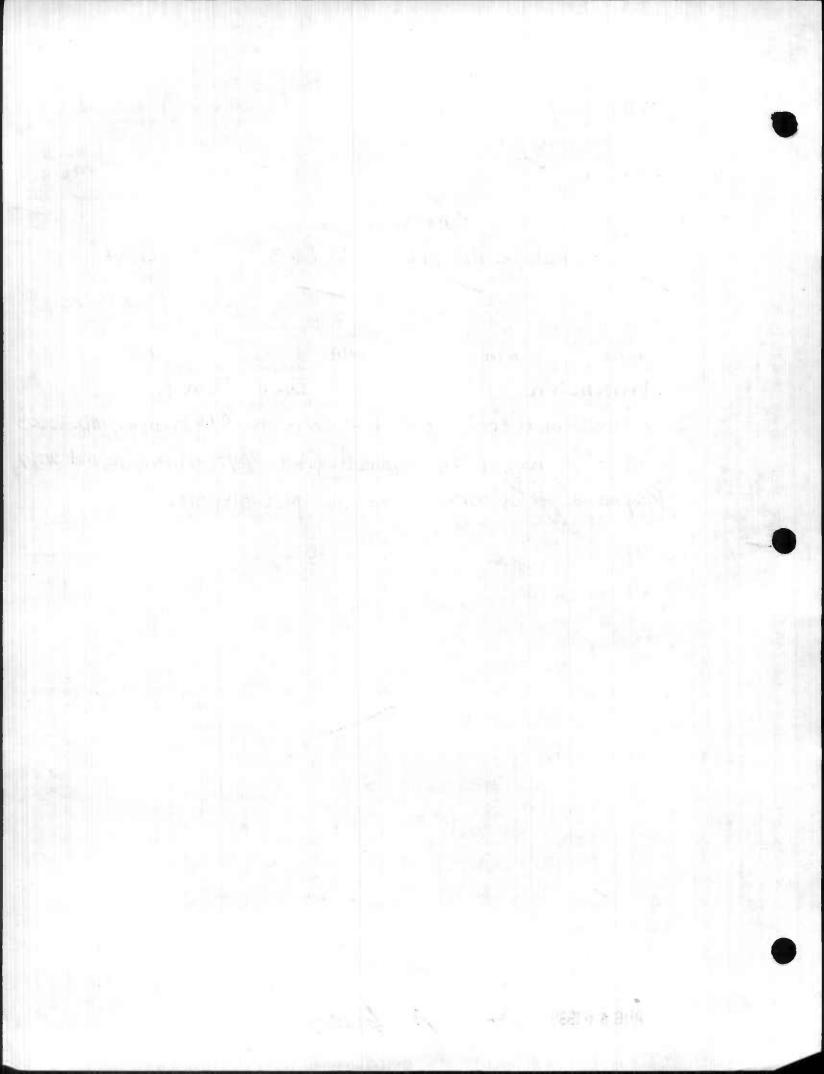
32. Registrar's Signeture

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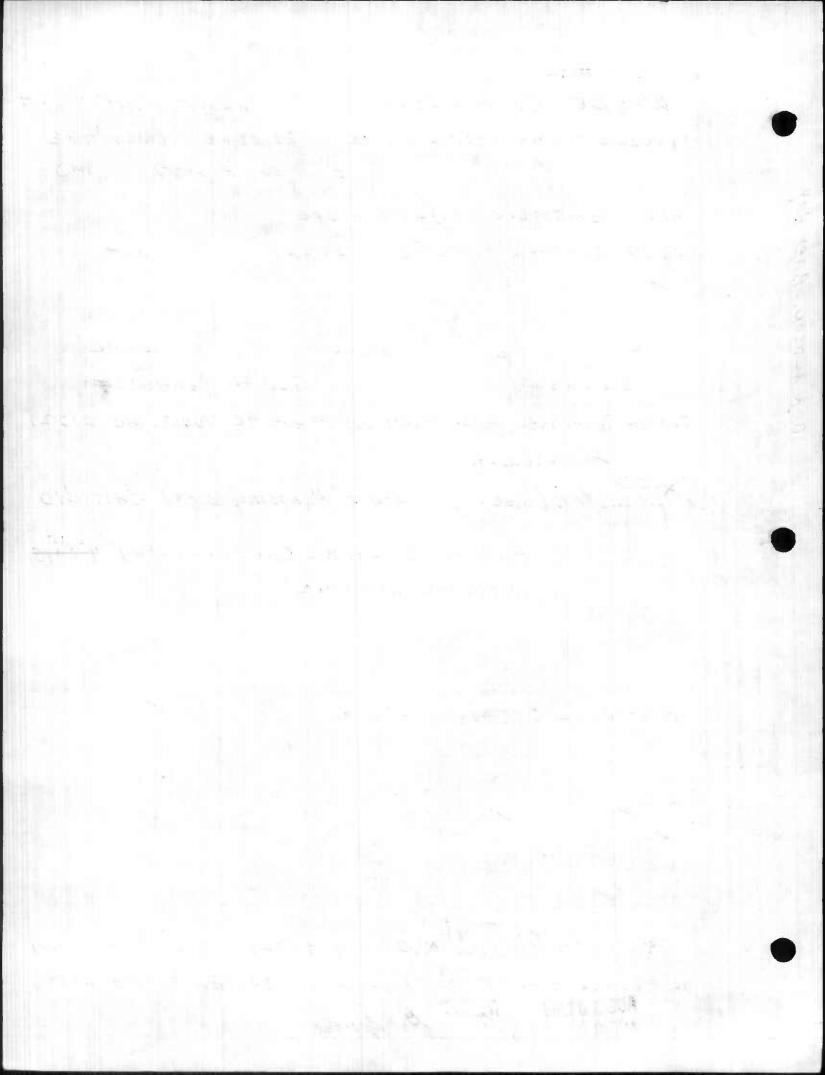
State Registrar



DONALDSON, BABY BOY

	Please Type or Prin	t In Black Indelible Ink.	Assure All Co	pies Are Legible
	State of Ma	ryland / Department of H	ealth and Menta	al Hygiene
FND#23a DED MD	G776 10-4-00 1 A	Certificate of L	Death	Reg No

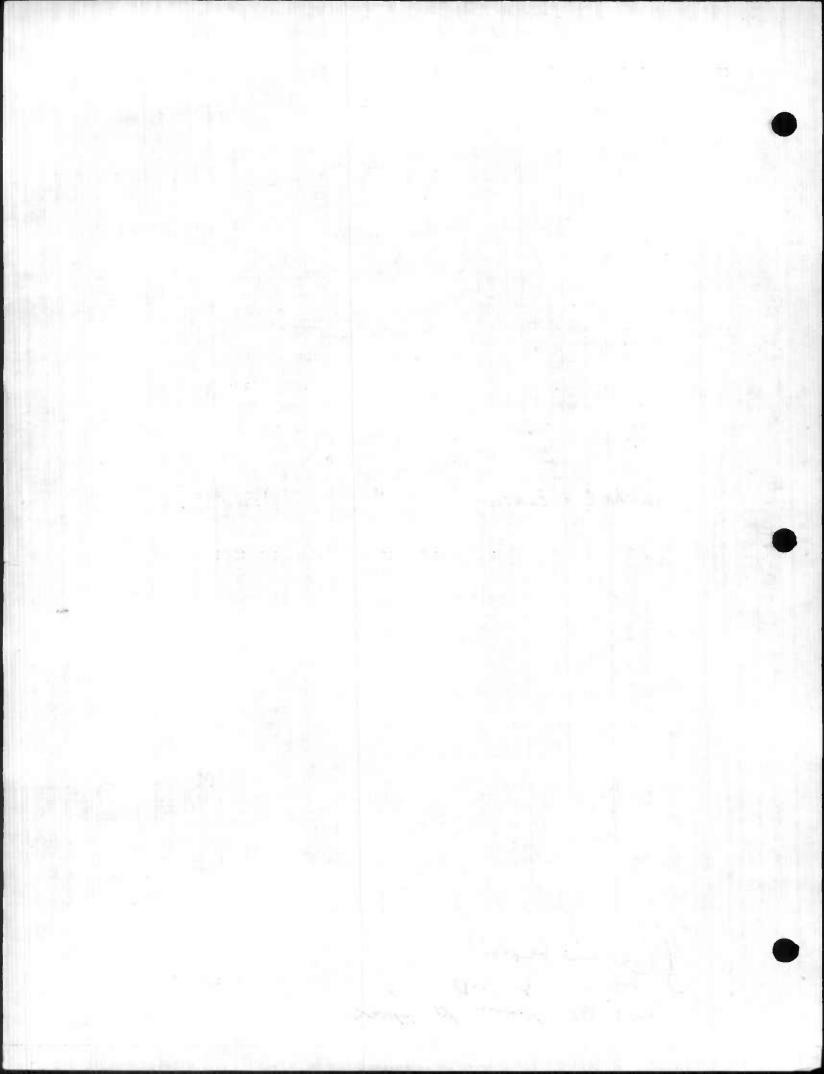
AME	ND#23a PER MD. G776 10-4-99 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. No.	3. Time of Death							
Physician /Medical	WAYNE DONALD SON	AUGUST 13	1999 1:06 P.M.							
Examiner	4e Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		nty of Death							
Funeral Director	FRANKLIN SQUARE HUSPITAL CENTRE LOSE 5. Social Security Number 6. Sex. 12 M 2 F 7. Age (In yrs. last birthday) Yrs. Wonths Days Hours Min. Months Days Hours Min.	F.D. ALE BALTINGE Irs. 8. Data of Birth (Mooth, Day, Year) 9. Birthplace (State or Foreign Country) M.D.								
2 1-	Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Insida City Limits							
vith the Mary t or 28s-f sho be notified a	MD BALTIMORE DACTIMORE 10e. Street and Number 101. Zip Code	100 Chinese	1 ☐ Yes 2 ☐ No # What Country?							
ath with 123s or nat be.	1604 Doolittle ROAD #C 21221		USA							
5-0020 72 hours after death w naturals, or itsems 23a dical Examines must.	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Waa Decedent of Hispanic Origin? (Sp. If Yes, apecify Cuban, Mexican, Puarto If Yaa, Giva Year or Dates: 13. Waa Decedent of Hispanic Origin? (Sp. If Yes, apecify Cuban, Mexican, Puarto I — Yes 2 — No Specify:	pecify Yas or No- Plican, etc.) 14. Race - American Indian, Black, Whita, atc. Specify:								
I 21215-0 ad within 72 ho typiere. we then "natural, the Medical. Completed	15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent'a Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)									
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Maryland 52 should be fill th and Mental Hy 7 is marked oth traumatic event To Be (the Donne								
S should be many	19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, City or Tow	m, State, Zip Code)							
- 6866	JUDITH DONALDSON, MOTHER 1604 DOOLITHE RO. *	+C, BACT.	140. 21221							
altimore mit. Pages 1: partment of Hs contant; if han r injury or oth	20a. Melhod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CONO VIT	Date 20c. Location	n - City or Town, Stata							
Ball Depart Import Import any in	21. Signature of Euperal Service Lipensee 22. Nama and Address of Facility STATE An ATOM	u Board	BAIT MO							
	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac mode, or heart failure. List only one cause on each line.	or aspiratory arrest,	Approximate Interval Between							
Physician / Medical			Onsat and Death							
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death certification of for use a	d									
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cord requir should		24a. Was an autopsy performed?	24b. Wara eutopsy findings available prior to complation of causa of death?							
I Rec		1□ Yas 240 No	1 Yas 2 No							
of Vital Re Physician: The I this certificate he rai director, page is To Be Com	25. Was cese referred to medical axaminar?	h (Check only one)								
	1 Yas 28 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	oma 5 ☐ Rasidance 6 ☐ C								
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Division of the or attending P as ofter death. al Director: After the in by the funers Certification:	3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)								
n 24 hour n 24 hou ne Funer pletely fill edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and red at the time, date and place	mannar as stated. e, and due to tha cause(s)							
To th within To th comp	29b. Signatura end titla of certifier 29c. License number 27 47 8 7 1		ned (Month, Day, Year) UST 13, 1999							
	30. Nama and addrass of person who completed cause of death (Italy 23a) (Type, Print) DR. (TELIPDA FILL-10TT 9000 FRANKLIN SQ. DK	//	no 21237							
State	31. Data filed (Manipolar Vendono 32. Segistrer's Signature	12,10	1 0 . 0 . 1							
Registrar	Alla A 1333 Agence B. Sparke									



Robert	Lee	Dietrich

Rok	pert Lea	e E	Dietrich #23 PART I, 27, 28A-F	State of M	larylar 74 8-3	nd / Depa	artment of Hartificate of	lealth and Death	Mental Hy	rgiene 9 9	2	7183	
		П	1. Decedent's Neme (First, Middle, La						2. Date of De Month	eath	Voor	3. Tima of Death	
3	Physicia /Medic		Robert Lee Di	etrich,	Sr.				Augus	t 15, 19	99	7:30 A.M.	
	Examin		4a Facility Name (If not institution, given	re street and number)			4b. City, Town, o	r Location of Deat	h 4c. County	of Death		
			Kingston Landing	, Choptanl	c Riv	er		Easton		Talb	ot		
	Funeral		,			last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th sv. Year)	9. Birthp	lace (State or Foreign try)	
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	2 8		Usual Residence of Decedent 10a. Stete 10b. County		10c C	ty. Town or Lo	cation					0d. Inside City Limits	
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Maryland 21215-0020	hould b d Menta marked marke	2	Emil C. Diet	rich	ich Bertha					Seaman Dietrich			
ar	of pure	19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or								er, City or Town,	State, Zip	Code)	
	and		Flora Mae Die	trich/Sp	OUS	238	09 Grov	e RD.,	Presto	on, Mar	ylar	nd 21655	
ore	-755		20a. Method of Disposition 1 🛱 Burial 2 □ Cremetion 3 □		20b. I	Placa of Dispos	sition (Name of netory or other pla	ce)	Date	20c. Location -	City or To	wn, State	
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ň	death e atter ed for u	Ca	Death Other standings and distance			data at ab a con	4-44	and the Donath	23b. Did tobacco use contribute to the cause of death?				
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200	Attending or death. ector: Atte by the fune	cati	2 Accident investigation	0 10 33		7:0	0 M 1 🗆	Yes 2(1) No				AT CAPSIZED.	
DIVISION	after death after death Director:	Certification:	3 Suicide 6 Could not b determined		jury - At h lc. <i>(Speci</i> i	(y)	et, factory, office			(Street end Numb wn, Stete)	er or Rura	I Route Number,	
2	le l					WATER			CHOPTANK	RIVER, TA	L80T (CO. MD	
		edical		ysician: To the best niner: On the basis o and manner st	f examina								
	To To To	Σ	29b. Signature and title of certifier	0 . 1)		29c. Licens			29d. Date signed			
			PIALLE	tem	/		0.0	C.M.E.		August 1	6, 19	999	
	4		30. Name and publiess of person who	completed cause of o	death (Iter		Print) L1 Penn S	Street,	Baltimor	e, Maryl	and 2	21201	
	Stat Registra		AUG 1 7 1999	3L Registr	rar's Signa	gare of	racks						

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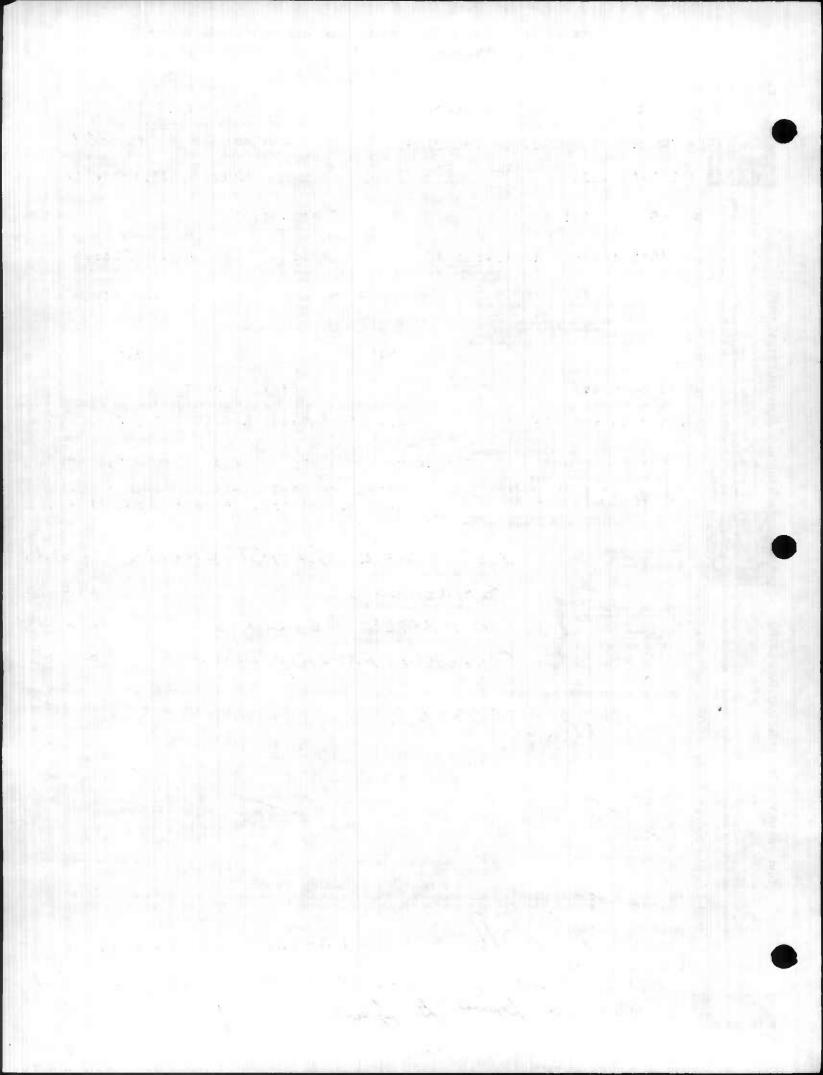


State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2. Data of Deeth 1. Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** Julia Grace August 12 1999 10:30PM Dawson /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Easton Talbot Genesis ElderCare -The Pines 7. Age (In yrs. last birthdey) 5 2 Yrs. If Under 1 Yaar If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1□M 2□XF Director 219-46-4272 June 8,1947 Maryland Usual Residence of Decedent with the Meryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itama 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at MD Talbot Sherwood 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7516 Tilghman's Island RD 21665 United States permit. Peges 1 and 2 should be filed within 72 hours efter deeth a Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 28a any injury or other treumetic avant Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yas, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indien, Bieck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Picker Crabbing 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middla, Last) Jacob Grace Mary J. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 17311 Brookmeadow Lane, Upper Marlboro, MD 19e. tnforment's Name/Reletionship (Type, Print) Sister Tonya Lacey/ 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 M Buriel 2 □ Cremetion 3 □ Removel trom State 4 □ Donetion 5 □ Other (Specify) Sherwood Cemetery 8/16 Sherwood, Maryland 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee Framptom-Hawkins-Eskow Funeral Home 23a. Part1. Entar tha disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. MD 21632 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) BREAST CANCER Examiner Examiner ARCOIDOSI. NONTHS ician end burief-transit Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest that the death certificate be exec 1 ABETES Division of Vital Records, P.O. Box 68760, physician MELLI TYS Physician/Medical the DISEASE (OROWAR USB Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 donknown 1 Yea 2 No by 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Dey Year) or Attending Patter death.

Olrector: After I After 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide A Hospital of 24 hours elemental D 29a. Certifier 1 Certifying Physician: To the best of my know nedge, deeth occurred at the time, date end place, end due to the cause(s) and menner as ateted. Medical 2 Medical Exa end/or investigation, In my opinion, death occurred et the time, dete and plece, and due to the cause(s) iner: On the basie of examination and manner stated. To the To the To the 29c. Licensa number 29b. Signatura and title of cog 29d. Deta signed (Month, Dey, Year) 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) EASTON MAKAS 62. Registrer's Signature SUS IPLEUILD AUE

State Registrar



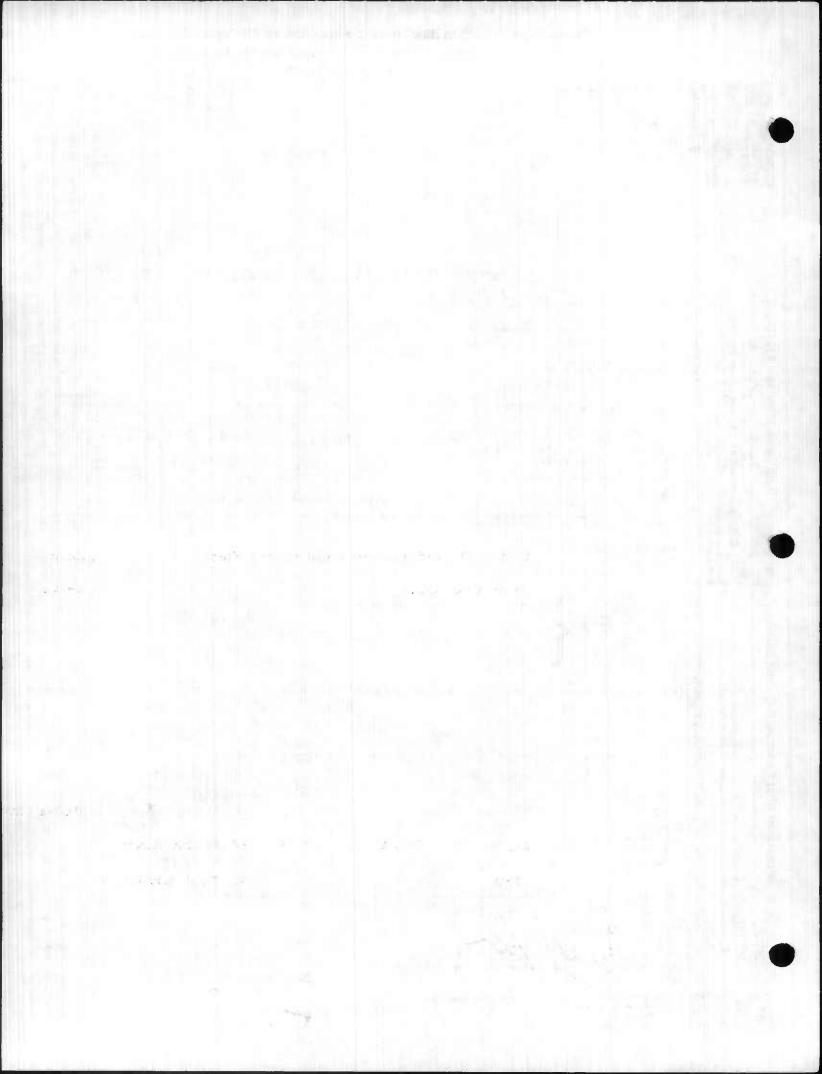
State of Maryland /	Department o	of Health and Mental Hygiene
		2 mm 1

Certificate of Death Reg. No. 2 Data of Death 3. Time of Deeth 1. Decedent's Nema (First Middle Last) Aug 16, **Physician** 1999 Charles Robert. Emerick 06:45pm /Medical 4e Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Route 36-Barrelville Outdoor Club Barrelville Allegany Hours Min. 8. Dete of Birth (Month, Day, Year) 931 7. Age (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** Deys 15 M 2□ F 67 Mb 215-34-4787 Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-4 show the Medical Examiner must be notified at 1 ☐ Yes �☐ No MD Allegany Mt. Director Savage 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 14600 Scenic Hillside Drive 21545 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelih and Mentel Hyglene. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Wed Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? ≠ElYes 2 □ No If Yes, Give Year or Datas Korea 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, Whita, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yas ♣☐ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) Elementery/Secondery (0-12) College (1-4or 5+) Retired Machinist CSX Transportation 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fethar's Name (First, Middla, Last) Raymond Emerick Beulah (Michaels) 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
14511 Mullaney Avenu; Mt. Savage, MD 21545 19e. Informent's Neme/Reletionship (Type, Print) Debbie L. Winters daughter 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Restlawn Memorial Gard8/19/ LaVale, MD 21. Signeture of Funerei Service Licenses 25 Carpets of Fauneral Home P.A. 21502 Cumberland, Maryland tt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disaese or condition rasulting in deeth) /Medical Self-inflicted gunshot wound to the chest sudden Examiner Due to (or es e consequence of): Examiner Major Depression 2 weeks attending physician end for use es the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or es e consequenca of): 23b. Did tobacco use contribute to the causa of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. eup 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown signed by Division of Vital Records. þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Outdoor Club 1 XYes 2 □ No 2 this funeral 28d. Dascribe how Injury occurred 27. Manner of Deeth 28b. Tima of 28a. Dete of Injury (Month, Dev Year) 28c. Injury et Work? Certification: or Attending Patter deeth. 5 Pending Investigation 1 Neturei 1 Yes 2 No Aug 16, 1999 9:00 A Subject Shot Himself 2 Accident 3X Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide Rte 36; Barrelville, MD Road To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and mariner as select.

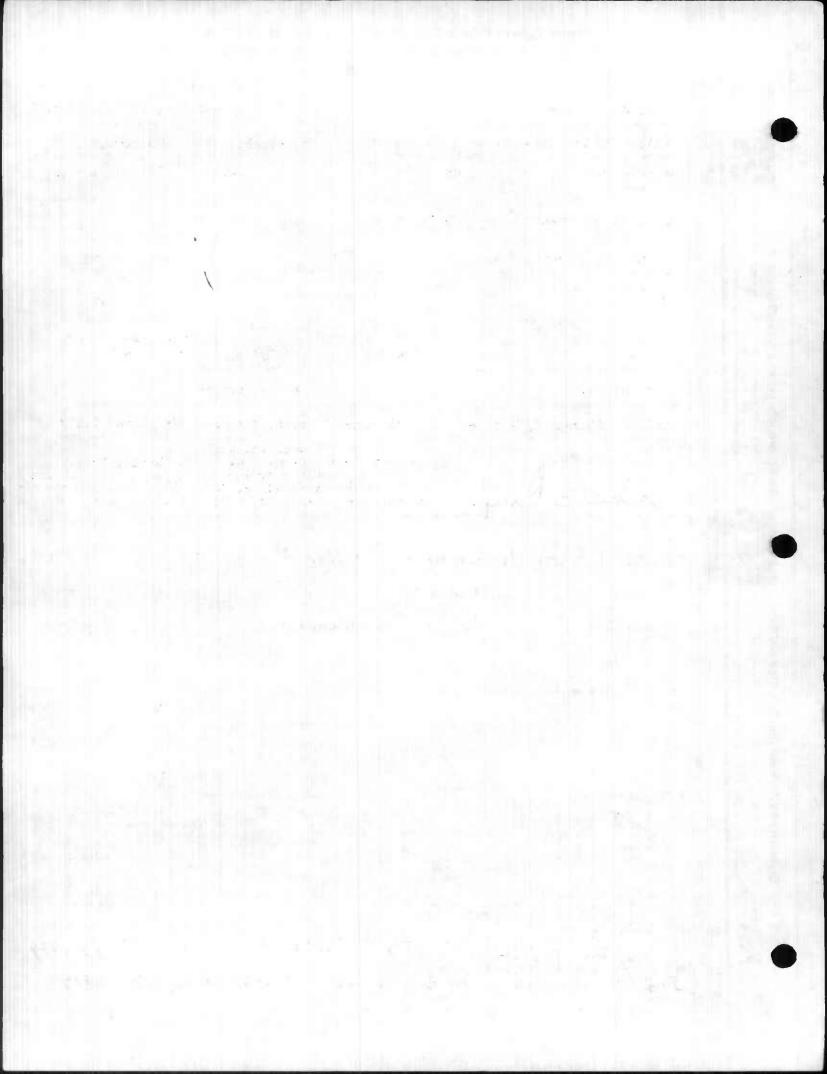
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, end due to the cause(s) end manner stated. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of cartifie D09157 Aug 16, 1999 no completed cause of death (Item 23a) (Type, Print) person w Snow M.D. Paul 124 W. 3rd Street Cumberland MD 21502 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture AUG 1 8 1999

DHMH 16 Rav 6/95

Registrar



Physician //Medical Examiner Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show introduction: If Item 27 is marked other than "natural" or items 23s or 28s-f show introduction: If Item 27 is marked other than than than 10s or 28s-f show introduction: Items 11 is the 10s of 11 is t	Sual Residence of Decedent Da. State 10b. County Maryland Montgome De. Street and Number 407 Russell Avenu Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 T. Father's Name (First, Middle, Last) Eric Anderson 9a. Informant's Name/Relationship (1) Linda E. Clevelan Da. Method of Disposition	e street and number) are Center are Center Are Center 7. Age 2 12. Was Decedent E Armed Forces? 1 1 Yes 2 N If Yes, Give Year or Dates: Jucation College (1-4or 5-	Gait	wn or Location nersburg 10f. 2 20 13. Was Dec If Yes, sp	er 1 Year Days ip Code 877 edent of Hierory	Ib. City, Town, or Lo Gaitherst If Under 24 Hrs. Hours Min. IspanIc Origin? (Span, Mexican, Puerto	ourg 8. Date of Bin (Month, Da June 16	Day 14, 19 4c. County Mont N, Year) 0, 1911	Year 1999 of Death 2 gomery 9. Birthplace Country) Connec 10d. f	(State or Foreign ticut Inside City Limits 18 Yes 2□ No		
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12. Speciment of Health and Mental Health and Me	Father's Name (First, Middle, Last) Eric Anderson 9a. Informant's Name/Relationship (I Linda E. Clevelan 0a. Method of Disposition)	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 Secretary 17. Father's Name (First, Middle, Last) 18. M						ontgomery County			
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n and had been and the set of the	9a. Informant's Name/Relationship (1) Linda E. Clevelar (a) Method of Disposition	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb						lanna Persson				
n and hand important: if item 2 important: if item	a. Method of Disposition	Type, Print)	19	b. Mailing Addre	ss (Street	and Number or Rura	lumber or Rural Route Number, City or Tow			vn, State, Zip Code)		
23 nysician Medical kaminer	1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placa) Aug. 16, 1999								yland 20817 tion - City or Town, State			
Medical Images	Montgomery Crematorium, Inc. Bethesda 21. Signatura Serve Lean 22. Name and Address of Facility Robert A. Pumphrey Bethesda-Chevy Chase, Inc. 7557 Wis M00803 Bethesda, Maryland 20814-3501											
Medical Images	3a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that seed one cause on each line	the death. Do	not enter the m	ode of dyin	lary Land ig, such as cardlac	or respiratory a	rrest,	App	proximate erval Between		
en and uriel-transit Examine	Immediate Cause (Final disease or condition resulting in death) a. hemorrhanic esuphyral varices Due to (or as a consequence of):											
			rhosi						1	rear!		
	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or Injury nat initiated events	1.	Due to (or as	a consequence o): U	1001			1	POL I		
0.0	resulting in death) Last								7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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be deteched for use by Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								3 Probabl			
2 should								an autopsy ormed?	availab	autopsy findings ble prior to etion of cause th?		
Com							10	Yes 2000	1□Ye	es 2 No		
25.	5. Was case referred to medical examiner?	Hospital.			100	26. Place of Death						
SE P	1 Yes 2 100	Hospital: 1 Inpatier 28a. Date of Injury		Outpatient 3	DOA Din	Nursing Ho		denca 8 Oth-				
After fune	1\times Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day n 28e. Place of Inju	Year)	injury M		Yes 2□No		Street and Numb		oute Number,		
	9a. Certifier 1 Certifying Ph	building, etc.	f my knowled	ge, death occurre	d at the tin	me, date and place,	and due to the	cause(s) and ma	nner as state	d.		
he Fune pletely fil edical	one)	niner: On the basis of and manner stat		ind/or investigation	on, in my o	pinion, death occurr	red at the time,	date and place,	and due to the	cause(s)		
within 2 To the complex	9b. Signature and title of certifier	Milni	RU	MI	9c. Licens	19254		Augus	d (Month, Day	Year) 1999		
	Name and address of person who	completed cause of de			NE	GAITI	4ENSDU	ec m	d 208	79		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Nezahat Hatice Eraybar Aug. 10, 1999 11:51AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. lest birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Monthe Deys 220-21-2223 78 Yrs 14, Dec. 1920 Turkey Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or Nems 23s or 28s-f show other traumetic avant, the Medical Examinal must be notified at 1 Yes 2 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1702 Pasture Brook Way 20854 Turkey Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. should be filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Eiementary/Secondary (0-12) College (1-4or 5+) Housewife At Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Lest) permit. Peges 1 end 2 should be fi Department of Health and Mental P Important: If Nem 27 Is marked of any Injury or other traumatic avan Hasan Basri Alev 2 Radife Hatice 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Relationship (Type, Print) Verle E. Lanier-Son-in-Law 1702 Pasture Brook Way, Potomac, MD 20854 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State Gate of Heaven 8/13/1999 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Joseph Gawler's Sons INC, 5130 Wisconsin Ave. 21. Signeture of Funeral Service Licanses any ir NW, Washington, DC 20016 homas Hombaker 23a. Pert1. Enter the disease, or complications thef caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) 7 days Examiner Examiner burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (de es a consequence of): and certificata be axec Box 68760 physician Physician/Medical the Due to (or as a consequence of): SE 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by encepholopach Division of Vital Records, ٥ 8 24b. Were eutopsy findings eveilable prior to 24a. Wes an autopsy performed? Completed completion of cause of death? certificate has 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 21 No P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menne of Deeth funeral 28e. Dete of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident aftar deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homloide 24 hours a Descritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner as stated. 29e. Certifie Medicai 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner steted. (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29c. License number 0 august 10 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Rockville **Davios** FRIEDMON RD SHADY 225 31. Dete tiled (Month, Dey, Yeer) 32. Registrer's Signature State 16 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene

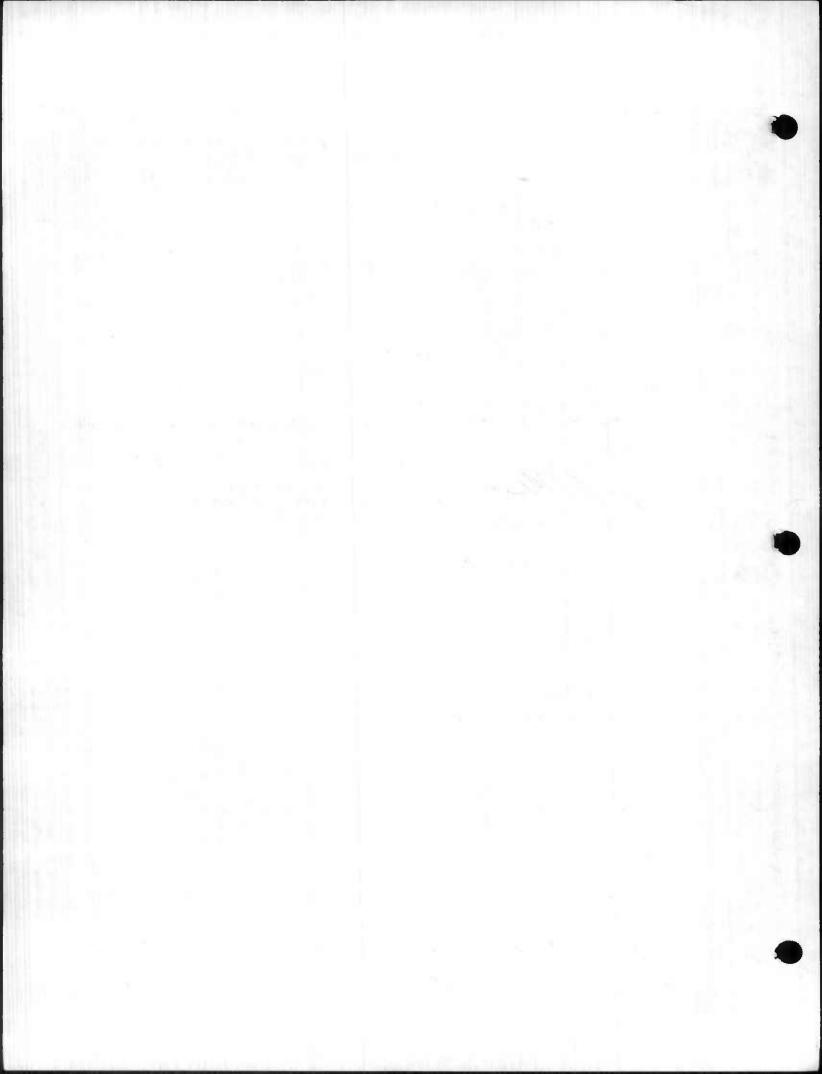
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Year **Physician** 18=15 Ginevra Mary Freeman 1999 AUG 16 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Harford Abingdon 648 Frans Dr. If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (Stete Country)
Sept. 23, 1921 Colorado 9. Birthplace (Stete or Foreign 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** Hours Deys Months 1□M 2₺F 545-14-2580 Director Usual Residence of Deceden the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 1 Tyes 20 No Directo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 21009 648 Frans Drive USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2X No
If Yes, Give 11 Meritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene.
ant: If Itam 27 Is marked other than "natural", or iten ury or other traumatic event, are Medical Examples. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify ò 35 Widowed 4 ☐ Divorced White Yeer or Detes: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Manager Arts & Crafts U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be John William Dawson Ginevra Mary Boyer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) 648 Frans Drive, Abingdon, MD 21009 Claudia L. Holman 20b. Piece of Disposition (Neme of cametery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from State permit. Page Department o Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. 8-18-99 Towson, Maryland 22. Name end Address of Fecility 21. Signeture of Funerel Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Muc 23e. Pert1. Enter the diseese, or shock, or heert feilure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final COLD. diseese or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): physician a P.O. Box 68760. Physician/Medical Due to (or es e consequença of) attanding pl ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, à 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed peed paga 2 1 ☐ Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 No 2 No this funeral 28a. Dete of Injury (Month, Dev Year) 28c. injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Neturel 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral Completally filled in the Funeral Completally filled in the second of the se 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and menner stated. 29a. Certifier edicai 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier 1999 DM G 30, Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10 MD FULFONO ANG MJ 21014 NASHO 31. Dete flied (Month, Dey, Year) AUG 18 32. Redistrar's Signature State Registrar

THE REPORT OF MET AND AFTER AFTER

State of Maryland / Department of Health and Mental Hygiene

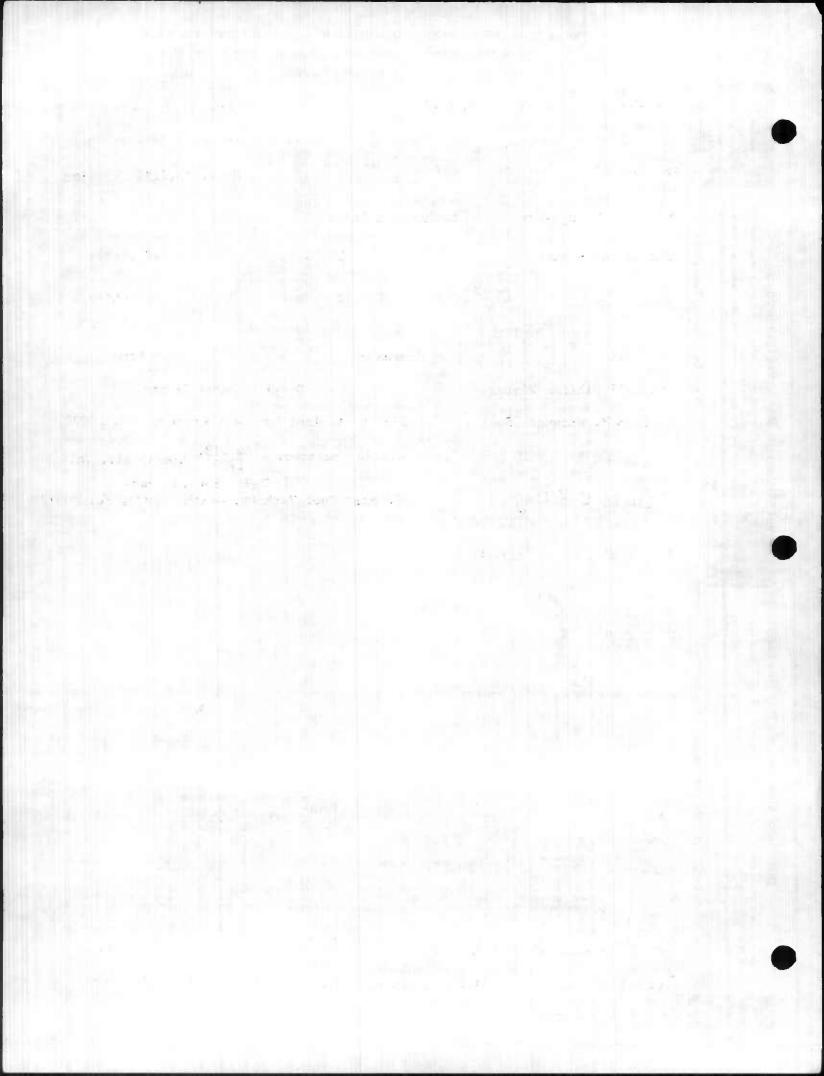
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П	Physic	ian	1. Decedant's Nama (First, Middla, Last)	1de				2. Data of Das Month	Day	Year	3. Tima of Death
	/Medi	cal	Mildred Gumaer Fie 4a. Facility Nama (If not Institution, giva str				4b. City, Town, or L		18, 199 4c. County		5:30 am
d	Exami	ner	614 Greenbrier Dri				Silver S			gomer	·V
	Funerai Director	Г	5. Social Sacurity Number 6. Sax		8 Yrs.	if Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept.	7 Year) 9, 1910	0	iace (Stata or Foreign try) York
-	p ,		Usual Rasidenca of Dacadant								
	ehov	5	10e. Stata 10b. County		ity, Town or Lo					10	0d. Insida City Llmits 1 ☐ Yes 2 ☑ No
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	ms 2:	Funeral Director		. Wes Decedant Evar in I	J,S. 13. V		fispanic Orlgin? (Sp an, Maxican, Puarto	pecify Yas or No-		e - Amarica	an Indian,
Maryland 21215-0020	ould be filed within 72 hours efter deeth with the Marylend Mental Hygiene. arkad other than "natural", or items 23a or 28e-f show site event, in Medical Exeminer must be notified	by	1 ☐ Navar Merried 2 ☐ Marriad 3)(1) Widowad 4 ☐ Divorced	Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas:		Yas, specify Cubi ☐ Yas 2X No	an, Maxican, Puarto Specify:	Rican, atc.)		k, Whita, a	
2-0	72 ho	Completed	15. Dacadant's Educa (Specify only highast greda o	tion	16a. Dacad	ant's Usual Occup	nation	16b. Kind of Businass/Industry			lustry
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and	that had be find the find of t	Be	17. Fether's Neme (First, Middle, Last) Chauncey Gumaer				18. Mothar's Nam				
7	ges 1 end 2 should be filed with to filed with to file Health end Mental Hygiene. If itsm 27 is marked other than or other traumatic event, Its.	2	19e. informent's Neme/Ralationship (Type	Drint)	10h Maitin	a Addrasa /Straat		osephine			Codel
	end 2 s ealth en n 27 is		Walter Swearingen Fiel					Rural Route Number, City or Town, Stata, Zip Code) New York, New York 10009			
re,	f Healtam if Healtam is		20a. Method of Disposition	20b.		ition (Nema of etory or othar place		Data	20c. Location -		
Ë	Pages nent of H int: If its iry or of		1 ☐ Burial 2 ☐ Cramation 3 ☐ Ran 4 ☐ Donation 5 ☐ Othar (Specify)	/19/99	Beltsville, Maryland						
Baltimore,	permit. Pages 1 end 2 Department of Health e Important: If item 27 is any injury or other tra once.		21. Signatura of Fugerel Sarvior License	/,	22.	e Cremat	ss of Fecility			1109	nar y rand
m	88 5 8	Rapp Funeral Se M00956 933 Gist Avenue							A. orina 1	Marvl	and 20910
	Physician /Medical Examiner		23a. Part 1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, auch as cardiac or raspiratory errest, interval B Onsat an Immadiata Cause (Finel disaasa or condition rasulting in daath) Bladder Cancer Dua to (or as a consequence of):								
	D 45	iner				.,					
	ificete be executed g physician end as the burlel-transit	edical Examiner	Sequentially list conditions, described by leading to immediate.								
60,	be ex ician buriel	a E	Sequantially list conditions, if eny, laading to immediate causa. Entar Undardying Causa (Disaasa or Injury c.								
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ň	es thet the death cert igned by the ettendin be detached for use	Physician/M	Part II. Other significant conditions contri	huding to double but not so	authion in the con-	de de la constant	ne le Dest I	nah Dida			Abo among of death 0
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S,	gned on del	ру Р	Colon Cancer, Ane	mia, Cardion	nyopathy	/					
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<u>ra</u>	vysician: The law ils certificete hes t I director, page 2 s	Bec	25. Was case rafarrad to medical				26. Plece of Deel	th (Check only o	na)		
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Division of Vital Records, P.O. Box	or Attending Physician: efter deeth. Director: After this certifical in by the funeral director,		2 Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injur Wor M 1 □	yat k? Yas 2 □ No	28d. Dascribe h	ow Injury occurr	red	
DIVIS	s efter de	Certification:	3 Suicida 6 Could not be 4 Homicida datermined	28a. Ptaca of Injury - At I building, atc. (Space	nome, farm, stre	et, factory, offica		28f. Location (S City or Tow	itreet and Numb n, Stele)	er or Rurai	l Routa Number,
	To the Hospital or Attending Phy within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Cartifier (Check only one) 1	lan: To the best of my kn r: On the basis of axamin end menner stated.	owladge, daath ation and/or Inv	occurred at tha tin astigation, in my o	ne, dete end placa, plnion, death occur	end dua to the d red et tha tima, d	ausa(s) and me sata and place,	ennar es sti and dua to	ntad. tha causa(s)
	To the Com	Ž	29b. Signatura and titla of cartifiar	\cap I	_	29c. Licans	a number		29d. Date signed	d (Month, E	Day, Year)
1	50		Susan H.	Homer	van m	DC96	03		August	18,	1999
	0		30. Name and eddress of person who comp								
			Susan H. Houseman,			Ivania A	ve., #6,	NW, Was	nington	DC 2	0037-3202
	Sta	ite	31. Data filad (Month, Day, Yeer)	32. Registrar's Sign	atura		,				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) AUGUST **Physician** NANCY FOROUGH MINTER 1147 1929 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 CENTOR STREET GROCK COTON HARACH MONTGOMERY If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours Min 1 M 20 F 74 579-24-2705 Yrs. Director Sept. 13,1924 Wyoming Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Md. Montgomery 1 ¥ Yas 2 □ No Washington Grove Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Center Street 20880 United States permit. Pages 1 end 2 should be filed within 72 hours effer death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e any Injury or other traumatic event, the Mexical Examples must page. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 11 Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Maxwell William Winter Carvl Hayward Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William M. Forquer (Son) 12536 War Admiral Way Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 18, Mertopolitan Crematory Alexandria, Va. 1999 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee Cueta 8.6 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical EMPHYSEMA Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 esn signed by the a 23b. Did tobacco use contribute to the causs of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 Vss 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s certificate hes 1 Yes 2010 Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No OL 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? atural 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi edicai 22 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signad (Month, Day, Year) 29b. Signa 29c. License number Mulo. AUGUST 17, 1994 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) MUS ROCKVILLE PORTE, ROCKVILLE, MID 20852 MARGOLLS, MO. 31. Date filed (Month, Day, Year) AUG 19 32. Begistrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GERTRUDE AUGUST 12, 1999 4:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY 8. Data of Birth (Month, Day, Year) SEPT. 30,1905 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Months Days Hours Yrs Director 577-18-9775 93 GERMANY Usual Residence of Decedent 10e State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director 28a-f MARYLAND MONTGOMERY CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2928 TERRACE DRIVE 20815 UNITED STATES Nems 23s 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 72 hours after 1 ☐ Never Married 2 ☐ Married ò 1 Yes 2 No Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be flied within hant of Health and Mental Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER INSURANCE COMPANY 12 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be HEDWIG KLEEBLATT JACOB STEIGERWALD of Health an out if Nem 27 is no vor oth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10001 HALL ROAD - POTOMAC, MARYLAND PETER FRANK (SON) 20s. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Spirally) 8/15/99 LEBANON CEMETERY ADELPHI, MARYLAND 21. Signature of Funeral Corvi 22. Nama and Addrass of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 28a. Part1. Enley the disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only ona cause on each line. Approximata Interval Batwe Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner mun physician and the burial-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? Completed cartificate hes page 1 Yas ZONo 1 Yas 2 No 25. Was case refarred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation deeth. 1 Yas 2 No the f 2 Accident siter deeth Director: / 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At horna, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours 1. Portifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2. Medical Examine() On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certi 29c. License numbe 29d. Date signed (Month, Day,)

10

Baltimore,

Box 68760,

P.O.

Records,

-RANK, GERTRUDE

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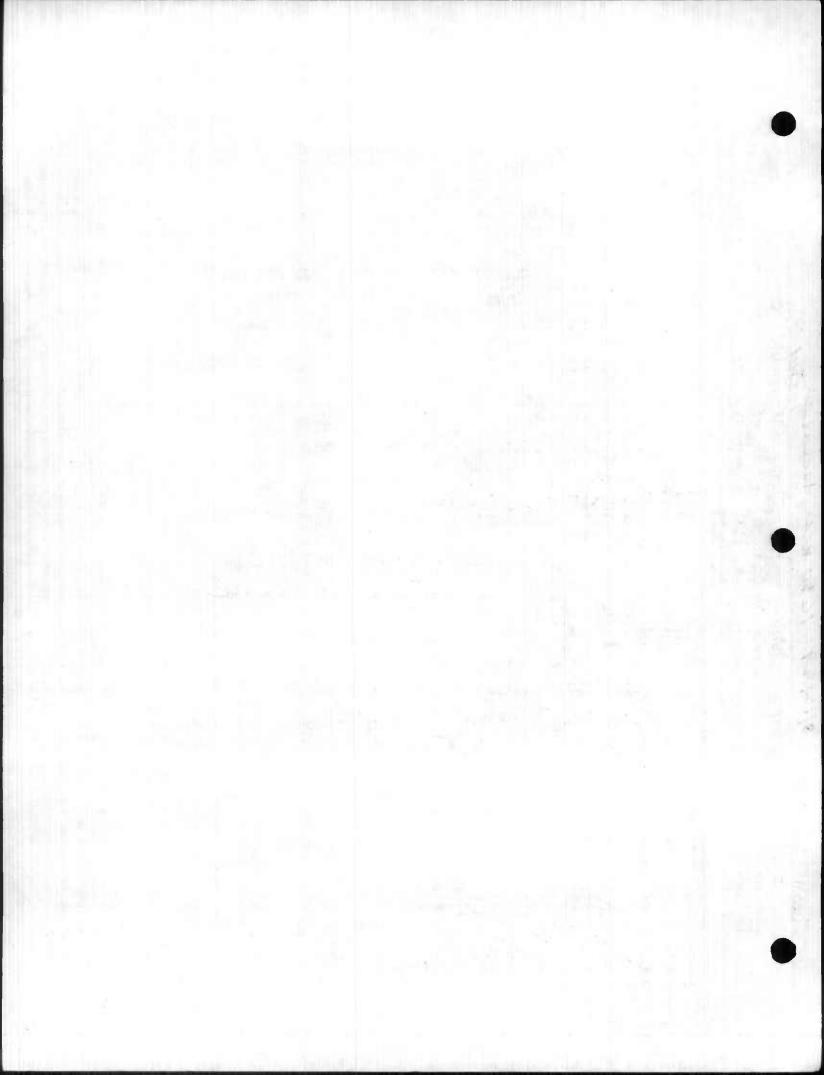
31. Data filed (Month, Day, Year) State AUG 17 Registrar

Elliot R. Goldstein, MD

9410 Old Gengetown Rd, 32. Registrar's Signatura Elect

morpleted cause of death (Item 23a) (Type, Print)

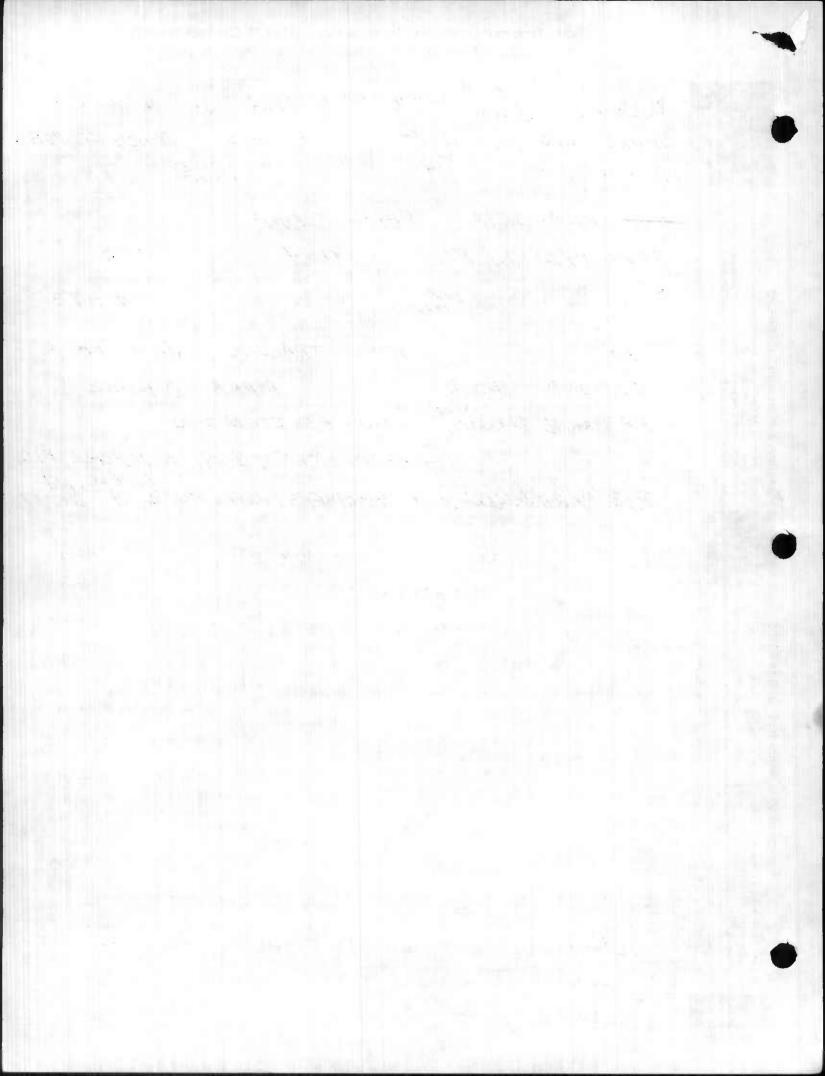
Betheadn NO



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #10a,8/16/99, BMW, Montg. Co. Certificate of Death AKA: ORMOND MICHAEL GAVIN 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 9:37 Am Michael 08 4e Fecility Neme (If not institution, give street and number) /Medical 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) H Under 1 Yeer H Under 24 Hrs. Honors Min. Honor, Month, Day, LAUREL REGIONAL HOSPT. PRINCE GEORGES 6. Sex 10 M 2□ F 5. Social Security Number Birthplece (Stete or Foreign Country) **Funeral** 178-42-0561 Usuel Residence of Decedent Director with the Maryland 10a. Stete РД 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hydiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Experies could be notified as page. 1 Pres 2 No PHILADELPHIA MD. Directo 10g. Citizen of What Country? 300 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 De Yes 2 □ No 16 Services (1998)
1 Yes, Give
1 Yeer or Detes: 1998 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) WOOD ORMOND 19a. Informent's Name/Reletionship (Type, Print) 5) STER 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ITEM #10 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 Cremetion 3 ☐ Removal from Stete CHAMBERS CREMATORY 8-16-99 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Line 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. 2073 Approximate Interval Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting In deeth) Cerefro vascular accident day s Examiner Due to (or es e consequence of): Physician/Medical Examiner thromboustopenie attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentielly llst conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Locterial Endoconditis Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicat exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral n 24 hours after death.

Ne Funeral Director: After th
pletaly filled in by the funeral 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signeture and title of continu 29c. License number 29d. Dete signed (Month, Dey, Year) . 14, 1999 53411 AA 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 20716 3060 mitchellville Rd Shesadri. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State AUG 16 1999 Registrar



		State of Mar		ertificate			I WENTAL FI	Reg. No.	9 2	/193	
Physicia: /Medica	171460	Last) ARET S. GLA	-55				2. Date of D Month	Dey 10	Year 99	3. Time of Death	
Examine	Suburban	tospital				Beth.		Mo	n gome	ry	
Funeral Director	5. Social Security Number 177-16-7987 Usual Residence of Decedent	6. Sex 7. Age ((In yrs. lest birthda) 78 Yrs.	Months	Days	If Under 24 H Hours M	8. Dale of B (Month, D MARCH	8,1921	9. Birthplace Country PENNS	YLVANIA	
Maryland ef show filed at	10a. Stale 10b. County		Oc. City, Town or I						10d	. Inside City Limits	
	MARYLAND MONTGO 10e. Street and Number 5600 WISCONSIN	AVENUE #909		10f. Zip 20	Code 815			10g. Citizen of UNITED			
-0020 hours after des bursi', or itsers at Examiner m	11. Marital Stalus 1 Never Married 2 Marrie 3 🖫 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? d 1 Yes 2 No If Yes, Give Year or Dates:	er in U,S. 13	Was Deced If Yes, spec		lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		14. Race - American Indien, Black, White, atc. Specify: WHITE		
Maryland 21215-0020 42 about be filed within 72 hours at th and Merial Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L.	Education grade completed) College (1-4or 5+)	(Giv	edent's Usua e kind of wor DO NOT us ELF EM	done retired	during most of v d)	vorking		Susinass/Indus		
Vland 2 uid be filed Mental Hygi rived other rife event, I	17. Father's Name (First, Middle, L MICHAEL SIMON	ast)				18. Mother's N MOLLY	lame (First, Middl		me)		
	19a. Informent's Name/Relationsh DAVID GLASS	p (Type, Print) (SON)	1360	2 ANCH	OR		Rural Route Num URT - RO	CKVILLE,	MARYL	AND 2085	
Baltimore, semil. Pages 1 ar separtment of Nes mportent: if Isem 3 my injury or other ones.	20a. Method of Disposition 1 🕅 Burial 2 Cremation 4 Donation 5 Other		JUDEAN N	ematory or of	her ple		8/13/99	20c. Location OLNE	- City or Town		
Departing Coperation of Copera	21. Signature of Fune (1) Service (1)	Mem	Ou	1170 R	SKY OCK	-GOLDBE	RG MEMOR IKE-ROCK	VILLE, M	IARYLAN	D 20852	
Physician /Medical	Immediate Cause (Final	omplications that caused the nly one cause on each line.	RENAL			ig, such as card	liac or respiratory	arrast,	In O	pproximata iterval Between insat end Death	
Examiner	disease or condition resulting in death)	a	ue to (or as a cons	equence of):						GEARS	
68760, ficate be assecuted ficate be assecuted physician and its the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events	Due to (or es a consequence of):									
death certificate be attending physicial of for use as the burned for the burned at th	resulting in death) Last	d.	e to (or as a conse	quence of);					!		
P.O. do by the detached	Part II. Other significant condition	contributing to death but			usa giv	en in Part I.				he cause of death bly 4番Unknow	
Records, a law requires the has been signe go 2 should be to the following the followi							24a. Wa	as an autopsy formed?	availa	autopsy lindings able prior to sletion of cause ath?	
E a despa			·			20 Disco of E	Deeth (Check only	Yes 2 No	101	ras 2017No	
Of Vita Physician: this certific ral director.	25. Was case referred to medical axaminer?	Hospital: 1图Inpatient	2 ER/Outpatio	ent 3 DO	Oth	or	Home 5 Re		har (Casaihi)		
On On O		28a. Date of Injury (Month, Day)	28b. Time		c. Injur			e how injury occu			
Division Prospital or Attending 24 hours after death. Funeral Director: After etely filled in by the fune	27. Manner of Death 1 8 Natural 2 Accident investige 3 Suicide 6 Could not determine	building, etc. ((Specify)		ry, office 28f. Location (Street end Number or Rural City or Town, State)						
7 5 7 6	(Check only 2 Medical E	Physician: To the best of r taminer: On the basis of ex and manner state	camination and/or i	nvestigation,	in my o	pinion, death or		a, data and place	, and dua to th	ne cause(s)	
of the second	29b. Signature and titla of certifier			29c	Licens	e number		29d. Date sign	ed (Month, Da	y, Year)	

29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) Barry Heel H. M. D.

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

3941 FERRALA DRIVE WHEATON, MD 2090 6

D19192

August 11, 1999

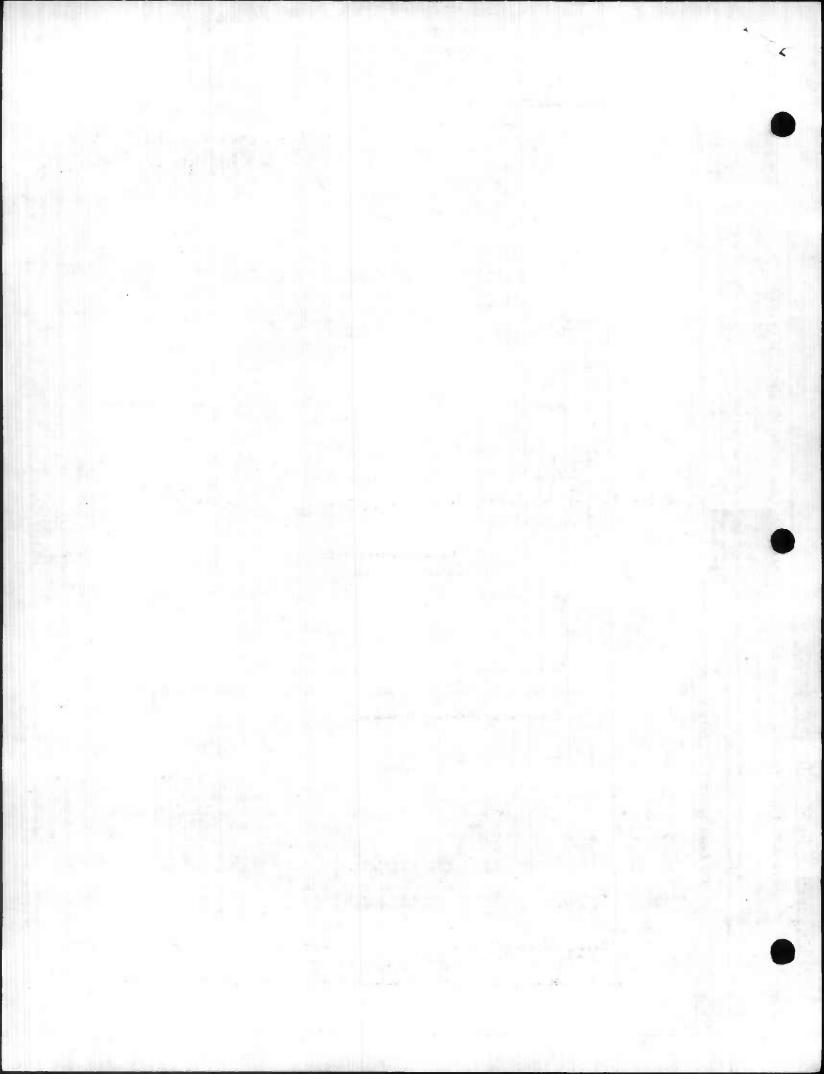
BARRY HECHT, MD

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature souls AUG 17 1999

20

Targaret, Glass 8110/99@ 11:55pm



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day August 17, 1999 0100 AM Richard E. Gill 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Ye 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year) Hours Months Days Min 15 M 2□ F Virginia Usual Residence of Deceden 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ₺ No Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 3202 Weller Road 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yas 2 No
If Yas, Giva
Year or Detes: Black, Whita, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Collega (1-4or 5+) Printing Press Man 18. Mother's Nama (First Middle Maiden Sumame) Alma L. Renner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) 17 Father's Neme (First Middle Last) Albert E. Gill 19a. Informent's Neme/Ralationship (Type, Print) Alma L. Gill (mother)

3202 Weller Road Silver Spring, Maryland 20906

20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, Stata Dala 8/18/99 Alexandria, Virginia Metropolitan Crematory

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

Strond Mry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Death

Immediata Cause (Finel disease or condition resulting in death)

20a. Method of Disposition

1 ☐ Burial 2 IX Cremation 3 ☐ Removal from Stata

5. Social Security Number

10a Stata

Maryland

11. Marital Status

10e Street and Number

219-42-3494

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Physician

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physician and the burial-transit

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page 2 s 98

cartificata

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After

To the Mospital or Attanding within 24 hours after death. To the Funeral Diractor: Afte completely filled in by the fun.

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that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attanding Physician:

The law requires

Examiner

Physician/Medical

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Completed

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To

Certification:

edical

4 Homicide

Baltimore, Maryland 21215-0020

a Small Cell Lung Cancer Dua to (or as a consequence of):

10 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). that initiated events resulting in death) Last

Due to (or es a consequence of): Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23h. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown

24a. Was an autopsy

1 Yes 2 No

24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No

25. Was case refarred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2♥ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No invastigation 2 ☐ Accident 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

30. Nama and eddress of person who complated causa of death (Item 23a) (Type, Print)

Ralph V. Boccia, M.D. 9707 Medical Center Drive Rockville, Maryland 20850 31. Data filed (Month, Day, Year)

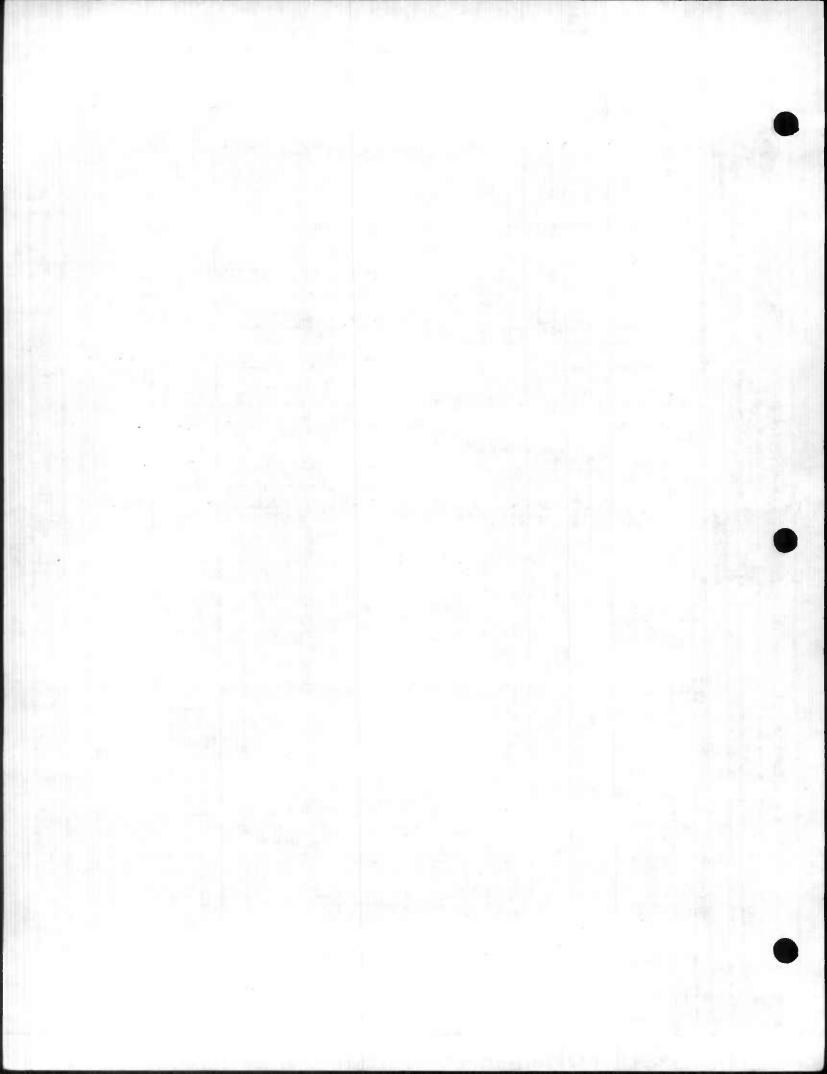
State Registrar

AUG 20 1999

32. Registrar's Signatura

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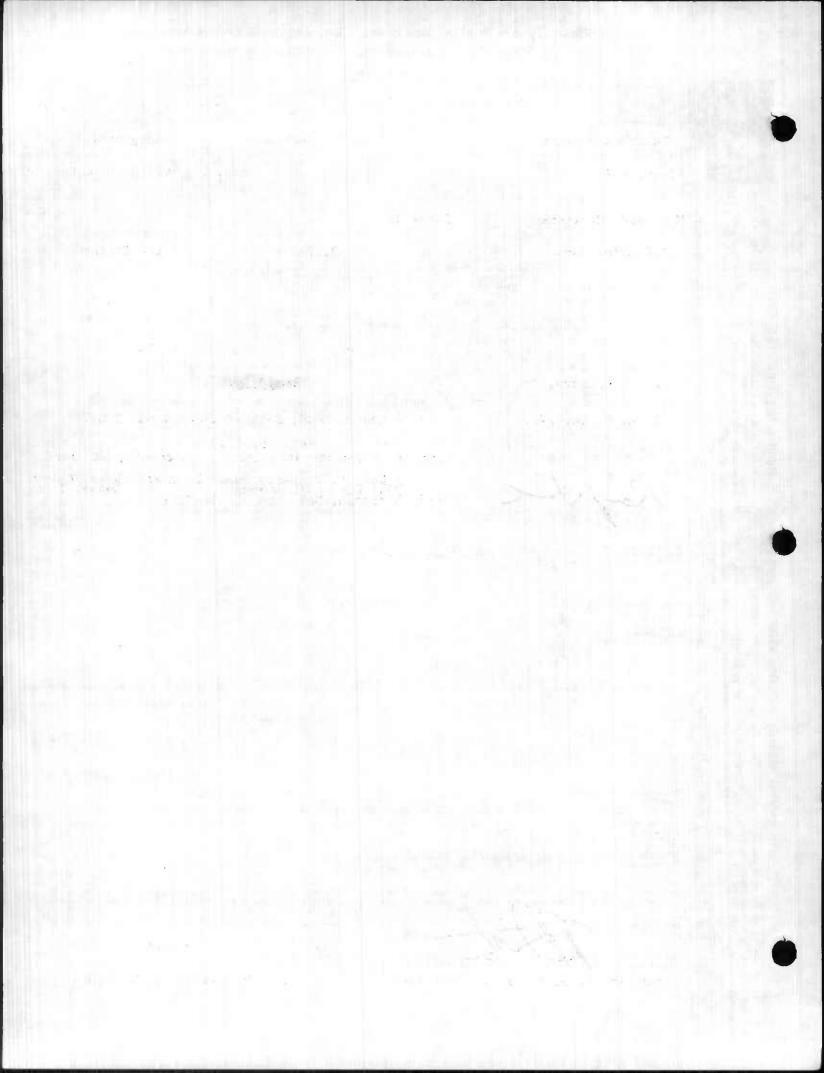
D 29675



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** John D. Gilmore, Jr. 12, August 1999 1:07 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□ F Hours Aug. 19, 1921 Washington, DC Director 579-07-9667 with the Maryland 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7104 Radnor Road 20817 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be John D. Gilmore, Sr. Mabel Duvall 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Neme/Relationship (Type, Print) Doris A. Gilmore/Wife 7104 Radnor Road, Bethesda, Maryland 20b. Place of Disposition (Name of cametery, cremetory or other place Aug. 15, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part1. Enter the disease shock, or hear failure. isease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ilure. List only one cause on each line. Approximete Injerval Between Onset and Death Physician /Medicai Immediate Cause (Final Metastatic Lung Cancer 1 year disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. lan/Medical Due to (or es a consequence of): 98 attending esn esn 0 Physic the bec Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: funeral director, Be 25. Was cese referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 21 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e 15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner as stated.

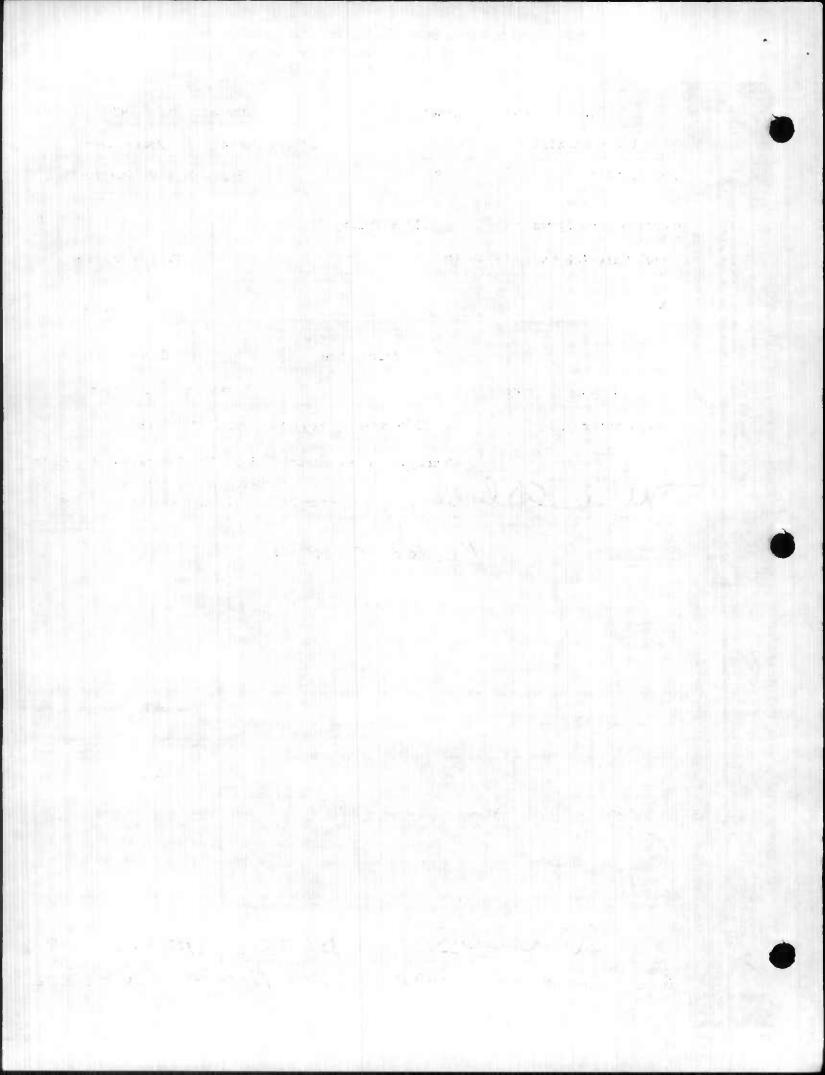
2 Medical Examiner: At the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of pertition 29c. License number D11506 August 13, 1999 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print) 5401 Western Avenue, N.W. Washington, D.C. Frederick P. Smith, M.D. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State AUG 16 1999

Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0

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State of Maryland / Department of Health and Mental Hygiene

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Y	/Medical Examiner	4a Facility Name (If not institution, give				4b. City, To	wn, or Locat	ion of Death	4c. County	of Death			
		EAST BOUND BAY	BRIDGE			Annar	polis		Anne .	Arund	lel		
-	Funeral			rs. last birthday)	If Under 1 Yea			Date of Birth (Month, Day,	Voorl	9. Birtho	olaca (State o	or Foreign	
п	Director	213-64-4846	280 M 2□ F	45 Yrs.	MOTRIS Day	S Hours		Jan. 6.	1954	Mar	vland		
	2 >	Usual Rasidence of Decedent	Lin	City, Town or L									
	anyle ahon	10a. Stata 10b. County		City, Town or L	ocanon					,	10d. Insida C	200No	
	vith the Mar or 28s-f a be notified Director	Maryland Harf	ord		Joppa							400	
	Dir	10e. Street and Number			10f. Zip Code		0.5	10	g. Citizen of		Hry?		
	23 rest	620 Dembytown Roa		. 110	W 5 4 4 4	210			14 Dec	USA	an tadas		
	72 hours effer death with the Maryland natural, or theme 23s or 28s-f show deal Examinar must be notified at sted by Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S. 13.	Was Decedent of If Yes, specify Cu	iban, Mexican	gin? (Specin) i, Puerto Ric	an, atc.)		ck, Whita,	can Indian, atc.		
20	urs eff.	1 Never Married 20 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates:		1□ Yes 2⊠ N	o Specify:			Specif	V: TATE	nite		
21215-0020	hour parties of be	15. Decedent's E		16e Dece	dent's Usual Occ	unation		1	6b. Kind of B				
15	ed within 72 ho yglene. er then "neturi it, the Medical Completed	(Specify only highest gra	ade completed)	(Give	kind of work don DO NOT use reti	e during most	t of working		OO. KING OF D	03111033/111	dostry		
212	within the	Elementery/Secondary (0-12)	College (1-4or 5+)		r/Operat				Const	ructi	ion		
D	EIPE W	17. Fathar's Name (First, Middle, Last,)	1 011210	18. Mother's Nam					-			
a	Mental H Mental H arked out atic aver	Lawrence Ray	Hoffman		Helen Hen					Jone	es		
Maryland	# SEE	19a. Informant's Neme/Reletionship (Type, Print)	19b. Maili	ng Address (Stre	et and Numbe	er or Rural R	oute Number,	City or Town	State, Zip	Code)		
	1 and 2 Heelth a em 27 la	Phyllis M. Hoffma	n - Wife	620 1	Dembytow	n Road	, Jopp	oa, Mar	yland	2108	35		
ē,	f Her f Hem othe	20s. Method of Disposition	90	Place of Disp	osition (Name of matory or other p				Oc. Location	City or To	own, State		
Baltimore,	Pages nert of ret. If the rry or o	1 Burial 3 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	1	on Cemet		8-1	19-99 D	arling	ton,	Maryl	and	
芸	Departm Importa any Inju	21. Signature of Funeral Service Uce	1111	/ /2	2. Nama and Add	lrass of Facilit	v				-		
m	Deg Hang	It. Va			McComas					21/	200		
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	nath. Do not en	1317 Cok	esbury	Rd.,	Ablinga spiratory arre	on, ML	210	Approximat	ia	
	Physician	shock, or heart failura. List only	ona cause on each line.						1	1	Interval Bat Onset and	tween	
	/Medical	Immediata Cause (Final	7 .	1	1 +1	1 11	04	0 /	1	1			
	Examiner	Immediata Cause (Final disaasa or condition rasulting in death) a. Drewing Completel & Multiple logiumes Due to (or as a consequence of):											
	je je		LUB (o (or as a conse	quence or);			,		1			
	cate be executed physician and s the burial-transit	Sequentially list conditions. Due to (or as a consequence of):											
o î	execution and market												
68760,	certificate be executed ding physician and use es the burial-transit n/Medical Examin												
89	ing ph e es th												
Box													
	0 0 2	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?				
P.0	by the tache							1 ☐ Ye	8 2 No	3 Pro	bably 4	Unknown	
s,	5 60 >								, ,				
D	been sign should be							24a. Was an		24b. W	ara autopsy i	findings to	
00	as been 2 should plete							patronn	.001	00	ompletion of o		
H.	0 - 2 =							1 X Ya	s 2 No	11	Yes 2	No	
a	certificate rector, pag	25. Was casa rafarred to medical				26 Place	of Deeth /C	theck only one		1	7		
of Vital Record	Physician: this certific ral director.	axaminar? 1⊠ Yes 2□ No	Hospitei: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA	Whor		5 ☐ Resider		ar (Speci	AT		
	orthic	27. Mannar of Death	28a. Data of Injury	28b. Tima o				. Describe hor			SCE	NE	
0	Attending in deeth. Setor: After by the fune	1 ☐Netural 5 ☐ Pending 2 ☐ Accident investigation	8/65/95	1) Injury		Yes 2	No &	abject.	Jujus	MI	Ridge		
Division	after deet Director: I in by the	3 Suicide 6 ☐ Could not b 4 ☐ Homicida determined	e 28a. Place of Injury - A	t homa, ferm, st	reet, factory, offic	9	28f.	Location (Str	eet and Nymi	ber or Run	al Route Nug	nber.	
Ö	tal or Attending P is after deeth. al Director: After tied in by the funer: Certification:	4 Homicida	Wolfe with	Low Me	mail Br	dar	Mb.	City or Town,	cithe de	+ and	weeks	12	
	y fill		yelcian: To the best of my										
	To the Hospital or Attent within 24 hours after desting to the Funeral Director: completely filled in by the Medical Certifical	(Check only one) 2X Medical Exam	niner: On the basis of exam and mannar stated.	ilination and/or in	vestigation, in my	opinion, deel	th occurred a	at the tima, de	te and place,	and due to	o the cause(s	57	
	To the Ho within 24 To the Fu completel	29b. Signatura and titla of certifier	V 2			nse number			d. Data signe				
		Theoder 1	6 King		0.0	C.M.E.		4	AUGUST	16,	1999		
		30. Nama and addrass of person who	completed care of death (Item 23a) (Type.	Print)								
	10	THEYDOREMIK	ng		enn Stre	et, Bai	ltimor	e, Mar	yland	21201	L		
	State*	31. Data filed (Month, Day, Year)	32. Registr s Si	gnature	4 1	-	,						
	Registrar	MG 1.8	1999	1	w. Ap	100							

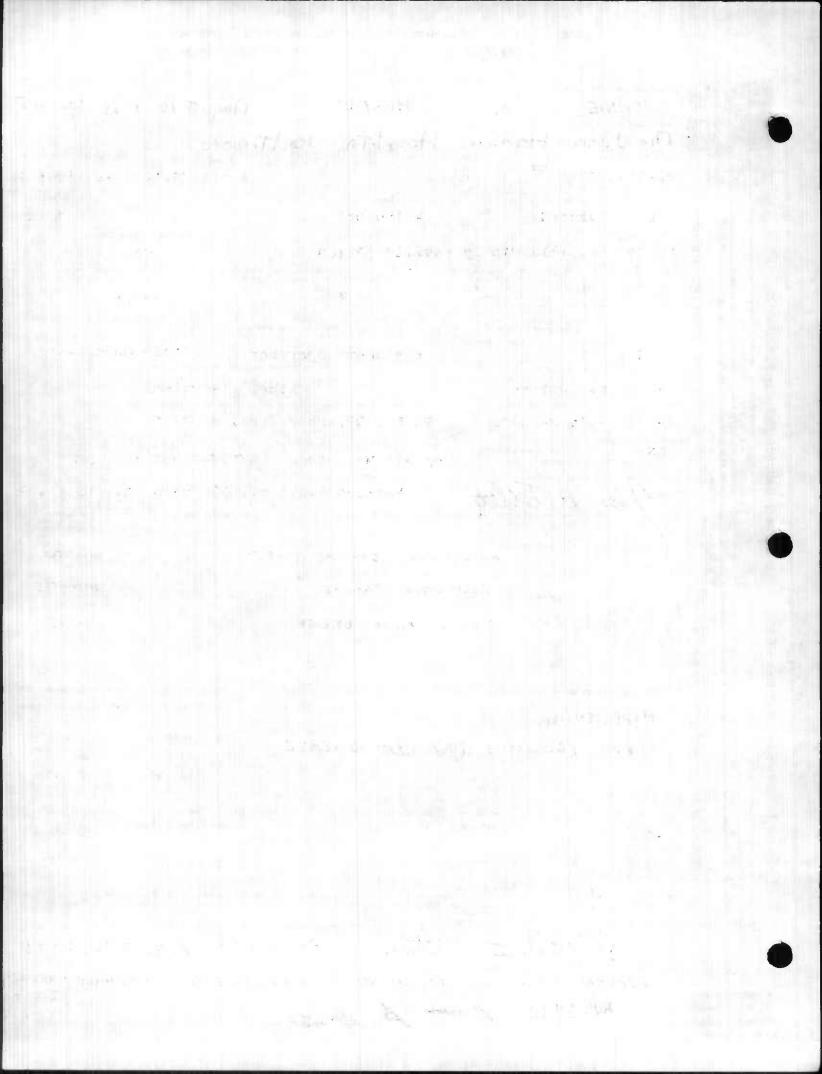


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** HULMES 06:35 JOHNIE Hugust 1999 16 R. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not Institution, give street and number) Examiner The Johns HOOKINS HOSP more 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** XXM 2□ F Months Days Hours Min 73 Director 220-20-0780 April 26,1926 WesVirginia Usuel Residence of Decedent with the Marylend 10d. Inside City Limits r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 1 □ Yes 2 200 MD Harford Whiteford Director 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number "natural", or Nems 23a or addical Examples results and 12. Wes Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 № 1 □ Yes PO Box 95, 1412 Old Pylesville USA pernit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or Items 234 any injury or other traumatic event, the Medical Examples from any injury or other traumatic event, the Medical Examples from any injury or other traumatic event, the Medical Examples from any injury or other traumatic event. Funeral 14. Reca - American Indien. Bleck, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White by 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Coltege (1-4or 5+) Elementary/Secondery (0-12) State Government Equipment Operator 8 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be **Holmes** Morrison Ethel Sturgess 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Jean L. Holmes- wife PO Box 95, Whiteford, MD 21160 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1900 Guriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Mem. Gdns 8/19/99 Bel Air, MD 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Harkins F.H.Inc., 600 Main St., Delta, PA 17314 A. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, ck, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical minutes CARDIAC ARREST BRADYCARDIC Examiner Due to (or es e consequence of): minutes Physician/Medical Examiner RESPIRATURU FAILURE physician end the buriel-transit the death certificete be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequença of): Years Box 68760, CORONARY ARTERY DISEASE thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 86 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? CHRONIC OBSTRUCTIVE PULMONARY DISEASE certificate has b 1□ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Hospitet Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Netural 5 Pending 1 Yes 2 No death. investigation 2 Accident ector: / 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 124 hours after to Funeral Direct plately filled in b 4 Homicide Hospital 29e. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner as stated edicai To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and titlerge RESIDENT RES-000 AUGUST 16, 1999 PHYSICIAN 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 00 BALTIMORE MARYLAND CATTANEO BLALOCK 655, 600 NORTH WOLFE STREET. STEPHEN 21287 31. Dete filed (Month, Dev. Year) AUG 17

State Registrar



P.O. Records, Division of Vital

> State Registrar

AUG 9 5 1999

we

29b. Signature and title of certific

MUSTUS

ely 32. Registar's Signature

ma and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

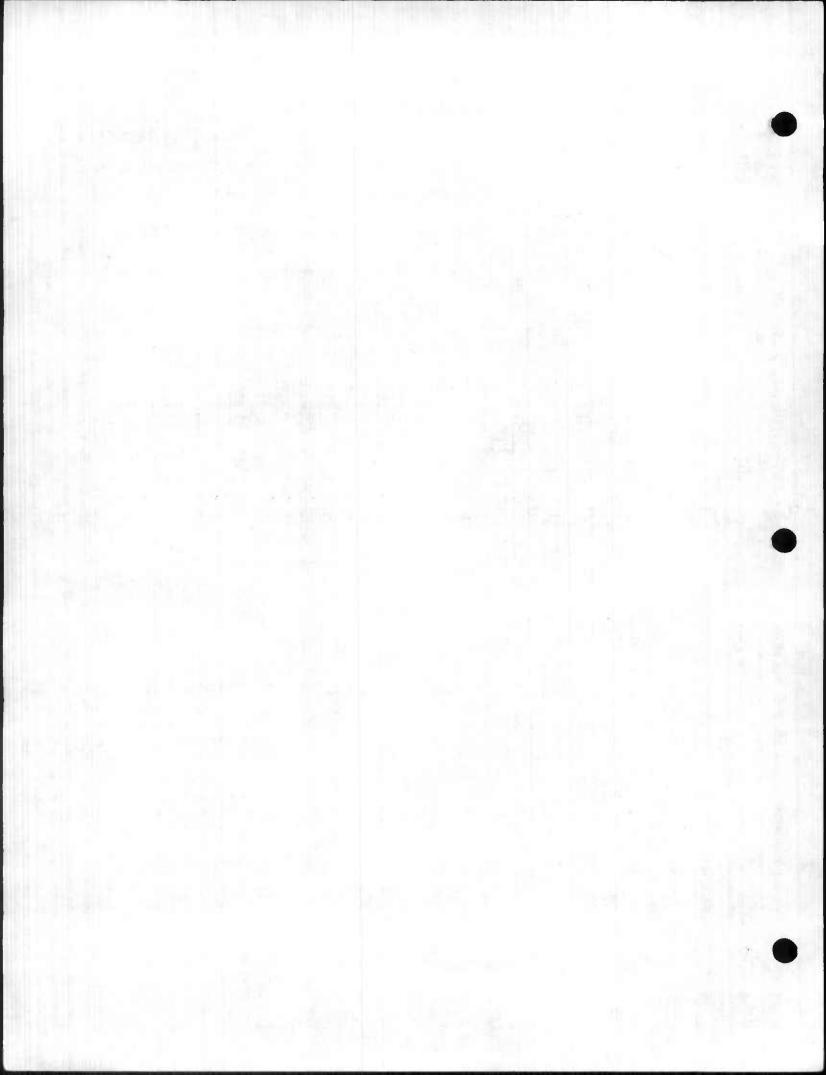
29d. Date signed (Month, Day, Year)

August 23, 1999

111 Penn Street, Baltimore, Maryland 21201

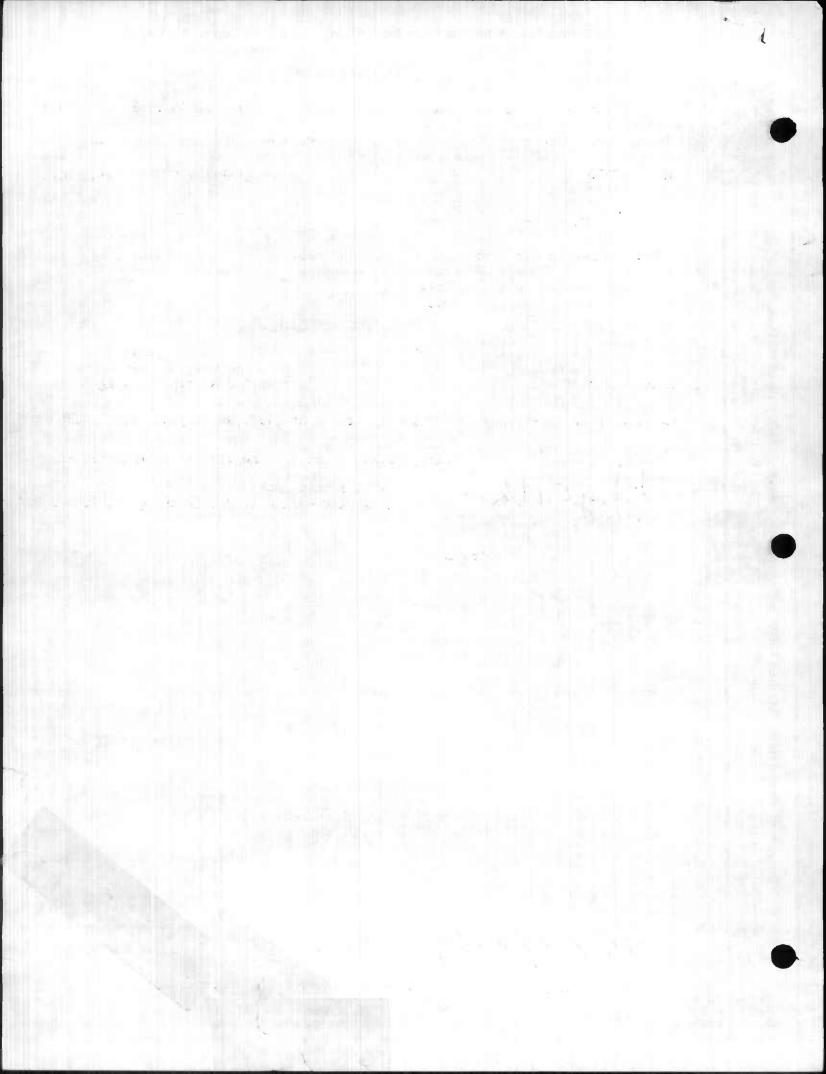
State of Maryland / Department of Health and Mental Hygiene

			Cei	runcate of	Dealli		Reg. No.			
Physician /Medical	1. Decedent's Name (First, Middle, Last) FREDERI		IOTT	HA	RT	2. Dete of De Month August		Year 10:05 c		
Examiner		KINS HO	SPITAL			IMORE		TIMORE		
Funeral Director	5. Social Security Number 6. Sex 247-70-9020	7. Age (In yn	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da Nov . 3	1943	9. Birthplace (State or Fore Country), Georgia		
death with the Maryland ms 23e or 23e-f show rmstbe notified at meral Director	10a. State 10b. County VA Fauguier	10c. C	City, Town or Lo	ocation	II	10d. Inside C				
or 28a-f s be natified	-				Hume			1 🗆 Yes 2 🛣		
Dire Dire	10e. Street and Number 14120 Hume Road			10f. Zip Code	00600		10g. Citizen of What Country? U. S. A.			
her death v r hems 23s siner.must Funeral		. Was Decedent Ever in	U.S. 13.1	Was Decedent of	22639 Hispanic Origin? (5	pecify Yes or No				
P 22 5	1 Never Merried 200 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cut 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerl Specify:	o Rican, etc.)	Black, White, etc. Specify: White			
72 ho	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Dece	dent's Usual Occu	pation during most of wo	rkina	16b. Kind of B	usiness/Industry		
d 21215-0 fled within 72 ho hygiene. finer then "natural ent, the Medical.]	Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retire 1ptor	9d)		Sculp	toring		
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Merital Hydgene. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	17. Father's Neme (First, Middle, Last) Frederick Wil	liam Hart			Joanna		, Maiden Suman : t	ne)		
	19a. Informant's Name/Reletionship (Types Lindy Lain Hart -	wife		ng Address (Stree O Hume Ro			er, City or Town, irginia	City or Town, State, Zip Code) Cginia 22639		
Baltimore, permit. Pages 1 at Department of Hear montant; if them: my injury or other ands.	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State	Place of Dispo cometery, crea art Cem	osition (Name of matory or other pla etery		Dete 20c. Location - City or Town, State /18/99 Hume, Virginia				
Balti permit. Departri Importa any inju	21. Signature of Funeral Service Licensee	Hombole		2. Name and Address			awler's			
	23a. Part1. Enter the disease, or complica							Approximate		
Ostificate be executed with the burish-fransit with th	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to	(or es a consec	quence of): quence of):	CE U			2 3 Month		
OX (d									
P.O. hat the de de by the detached Physic	Part II. Other algorificant conditions contri	iven in Part I.	23b. Did tobecco use contributa to the cause 1 XYes 2 No 3 Probably 4 □							
requir							an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of death?		
The lay ate has page 2						10	Yes 2KNo	1 ☐ Yes 2 No		
Vital I	25. Was case referred to medical examiner?					ath (Check only	on <i>e)</i>			
OT VITA Physician: this certific ral director,	1 Yes 2 No	, ,	ER/Outpatier	N 3LI DOA		_	idence 6 Doth			
nding ath. r: Atte	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	Yes 2 No		how injury occur	No.		
DIVISION THE NOTE OF THE NOTE OF THE NOTE OF THE NOTE OF THE OF T	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office			wn, State)	per or Rural Route Number,		
Divis To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th Medical Certific	29a. Certifier (Check only one) Signature Certifying Physic	lan: To the best of my kr r: On the basis of examir and manner steted.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	ime, date end place opinion, death occu	e, end due to the urred at the time,	cause(s) and me date and place,	enner as stated. and due to the cause(s)		
To the vithing of the state of	29b. Signature and title of certifier	M N	10.	29c. Licen	se number			d (Month, Day, Year)		
	30. Name and address of person who com	pleted cause of death (the			REET, B	ALTIM	ORE, M	D 21287		
State Registrar	31. Date filed (Month, Day, Year) AUG 1 6 1999	32. Registrar's Sign	gature g.	Spark	2					



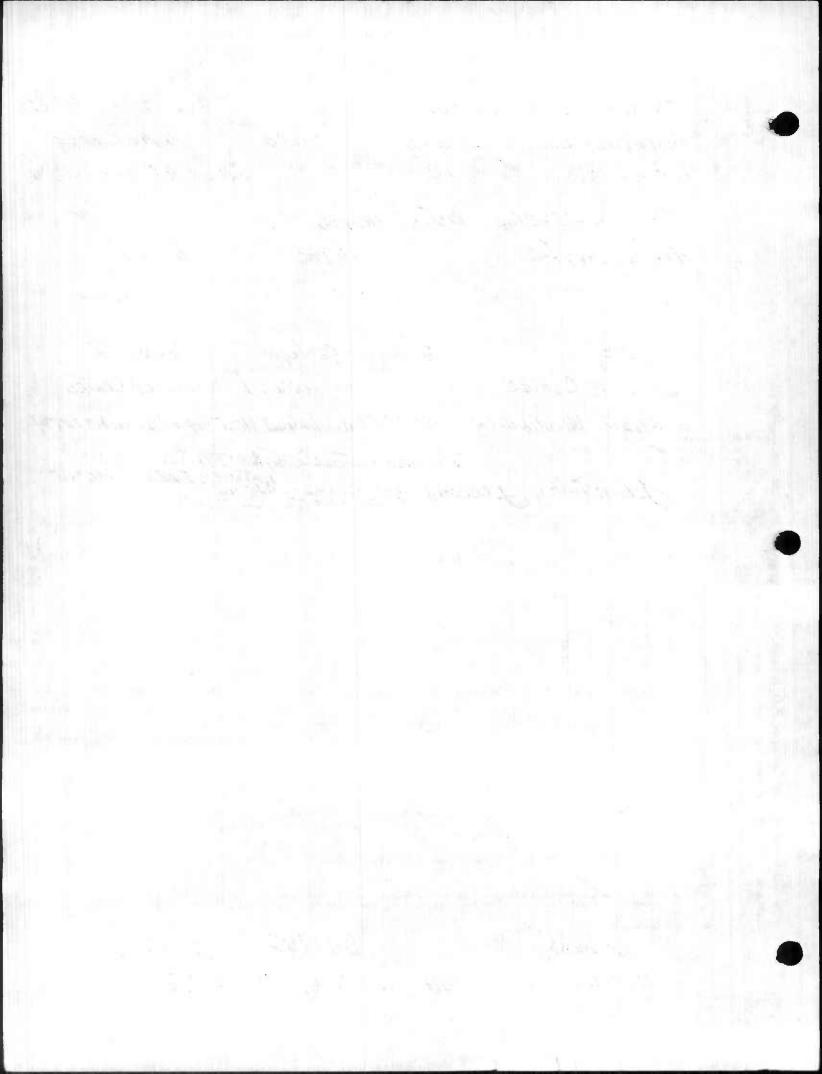
State of Maryland / Department of Health and Mental Hygiene

						Cer	titicate	OI I	Death			R	eg. No.	-	1 60 0	
Dhusisian	1. Decedent's Name (First,	Middle, La	st)								2. Dat	e of Deat	th Day	Year	3. Time of Death	
Physician /Medical	Cathe	rine	Agne	s I	lasso	n							15,19		4:50 PM	
Examiner	4a Facility Name (If not ins	titution, giv	e street and nu	umber)				4	4b. City, To	wn, or Lo	cation	of Death	4c. Co	unty of Dea	ath	i
	Manor Care	Poto	mac						Poto	nac				ontgo	mery	
ineral	5. Social Security Number	6. S	ex □M2K7F	7. Aga (In)		-	If Undar 1 'Months D	ear ays	If Under Hours	24 Hrs. Min.	6. Dat	e of Birth	Year) 1905	9. Bi	rthplace (State or Foreign country)	
ctor	577-18-7350		U (V) 245) (93		Yrs.					Oct	.15,	1905	Wa	sh., D.C.	
Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inaide City Limits	-				
×	224			100.			ation								1 Yas 2 No	
Director		Montg	omery		Poto	mac	T							****		
F	10e. Street and Number						10f. Zip Co					1		n of What C	ountry?	
ig.	10714 Potom	ac Te							0854					.S.A.		
Funeral	11. Marital Status		Armed F			13. V	Vas Deceden Yas, specify	t of H Cuba	lispanic Ori an, Maxicar	gin? (Sp	Rican,	s or No- atc.)	14.	Biack, Wh	arican Indian, ite, etc.	
Dy F	1 Nevar Marriad 2 3 ☐ Widowed 4 ☐ Div		If Yes, G	2□No 19	941-	1	☐ Yes 2€	No	Specify:				Sp	ecify:	white	
			Year or I	Jates: 1		Donald							10h Vind			
Completed	(Specify only	cedent's Ed highest gre	de completed;)	168.	(Give I	ent's Usuai C kind of work o O NOT use i	tone i	durina mos	t of work.	ing		100. King	of Business	s/industry	
E	Elementary/Secondary ()-12)	College	(1-4or 5+)	Nu	rse	0.107.000.	O LIII O C	-/				1	Nursi	ng	
	17. Father's Name (First, N	liddle Last)							18. Mothe	r's Name	e (First	Middle I	Meiden Su			
o Be	John Desmon													Norli	ng	
2	19a. Informent's Name/Re	ationship /	Type, Print)		19h	Mailin	g Address (S	treet				-			0	
	James R. Mi			2V			_								. 20036	
	20a. Mathod of Disposition	onaz,			b. Piace of	Dispos	ition (Name	of			Date				r Town, State	-
	1 ☐ Burial 2 ☐ Crem			Stata	cemeter	y, crem	atory or othe	r plac	place)							
	4 Donation 5 Ot			Me	etrop		tan Cr	_			ug. I	.8,95	ALE	exand	ria, va.	
	21. Signature of Fineral Si	ervica Licar	1 1 1				Name and A									
a	1 / w	10.	VUL				222 Wi				. N.	W W	Vashi	ngton	, D.C. 20007	,
	23a. Part 1. Enter the disease shock, or beart fellule	sa, or com	piications that	caused the d	eath. Do r	not ente	r the mode o	f dyin	ng, such as	cardiac	or respi	ratory arr	est,		Approximate interval Between	
n															Onset and Death	
l r	Immediate Cause (Finel disease or condition		С	olon c	ancer	2									years	
	resulting in death)		a.	Due t	o (or es a o	conseq	uence of):									
ine		_	h													
Examiner	Sequentieily list conditions		0.	Due t	o (or as a o	consequ	uence of):									
	Sequentielly list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	•														
dica	that initiated events resulting in death) Last		V	Due to	o (or as a c	onsequ	ience of):									
VMedical		L	d													
lan			u													
Physician	Part II. Other significant co	nditions o	ontributing to o	leath but not	resulting in	the un	derlying caus	se giv	en in Part		23	b. Did to	obacco us	e contribu	te to the cause of death?	
Phy												1 🗆 Y	es 20	No 3□	Probably 4 Unknown	a
by																
ted											24	a. Was a perform	n autopsy med?	24b	. Were autopsy findings available prior to	
ple															completion of cause of death?	
Completed												1 🗆 Y	es 2K	No	1 ☐ Yea 2 ☐ No	
Be C	25. Was case referred to m	edicai							26. Piece	of Deet	h (Chec	k only or	10)			
O	examiner? 1 Yes 2 No		Hospitai:	Inpatient 2	2 □ ER/Ou	tpatient	3□ DOA	Oth	or:					Other (Sp	ecify)	
	27. Manner of Death		28a. Date	of Injury	28b. T	Time of		Injur		-	_					
	1 ⊠Natural 5 □ Pending (Month, Dey Year) Injury Work?															
atio	2 Accident	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str.												Number or I	Rural Route Number,	1
ificatio	3 ☐ Suicide 6 ☐ 9	Could not be determined	200.1100	ling, etc. (Spi	ecity)						Cit	y or Town	ii, Stare)			
ertificatio	3 ☐ Suicide 6 ☐ 6		build													
ai Certification:	3 Suicide 6 0 4 Homicide	rtifying Ph	ysician: To the	e best of my												
dical Certificatio	3 Suicide 6 0 4 Homicide	rtifying Ph	ysician: To the	e best of my											ea stated. ue to the cause(s)	
Medical Certificatio	3 Suicide 6 4 Homicide 29a. Certifiar 1 Confection 1 Check only 2 Me	rtifying Ph	ysician: To the	e best of my			estigation, in	my o				e time, d	late end pi	aca, and U		
edicai	3 Suicide 6 4 Homicide 29a. Certifiar (Check only one)	rtifying Ph	ysician: To the	e best of my			estigation, in	my o	pinion, dea	th occur		e time, d	late end pio	aca, and u	nth, Day, Year)	
edical	3 Suicide 4 Homicide 29a. Certifiar (Check only one) 29b. Signatura and titler of (rtifying Ph dical Exam certifier	ysician: To the hand man	e best of my passis of exemner stated.	nination en	d/or inv	estigation, in	my o	pinion, dea	th occur		e time, d	late end pio	aca, and U	nth, Day, Year)	
edicai	3 Suicide 4 Homicide 29a. Certifiar (Check only one) 29b. Signatura and titler of (Check only one)	rtifying Ph dical Exam certifier	ysician: To the hiner: On the band man	e best of my pasis of exem nner stated.	nination end	d/or inv	estigation, in 29c. L	my o	pinion, des	31	red at th	e time, d	Augus	signed (Moi	nth, Day, Year)	
edicai	3 Suicide 4 Homicide 29a. Certifiar (Check only one) 29b. Signatura and titler of (rtifying Ph dical Exam certifier erson who	ysician: To the hand man	e best of my pasis of exem nner stated.	nination end	d/or inv	estigation, in 29c. L	my o	pinion, des se number 003878	31	red at th	e time, d	Augus	signed (Moi	nth, Day, Year)	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of Maryla			of Death		eg. No.	Es I ha Who
	Dhusis		Decedent's Name (First, Middle, Last	(1)				2. Dete of Deat	h	3. Time of Leath
U	Physici /Medi		Christine	Hawken	۵		-,	Month 8	Day 12 Ye	985
	Examir	ner	4a. Facility Name (If not institution, give					Location of Deeth	4c County of E	Death
-		_	MANOR CARE HAUTH 5. Social Security Number 6. S	SERVICE, LARGE	o MO, s. last birthday)	If Under 1 Y	LARGO Year If Under 24 Hrs	R Date of Birth	PRINCE	GERGE
	Funeral Director			□ M 2 1 7 9	Yrs.		ays Hours Min		1918 M	Birthpiace (State or Foreign Country)
	nylanc how		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	8a-f s	ecto	MD TRINCE	SEORGE SI.	SIRICI	HEIGH	H13			1€Yes 2□No
	with the or 2	Funeral Director	10e. Street and Number	2/2		10f. Zip Co		1	Og. Citizen of Wha	t Country?
	death	nera	11. Marital Status	12. Was Decedent Ever in	U,S. 13. V		of Hispenic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-		American Indien,
21215-0020	d within 72 hours after death with the Meryland jiens. r than "natural", or items 23s or 28s-f show the Medical Examine must be notified at	by	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:		Yes, specify Yes 2		to Rican, etc.)	Specify: L	White, etc. BLACK
15-0	natur	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. Deced	ent's Usual O kind of work d	ccupation one during most of wo stired)	rking	16b. Kind of Busine	ess/Industry
121	within ena. then	dmo	Elementery/Secondary (0-12)	Coilege (1-4or 5+)	Crorp	O NOT use n	GED OCIS	-	Carson	717
	al Hygi other	Be Co	17. Father's Neme (First, Middle, Last)		GEOGRA	April -	1-0-1	me (First, Middle, A	faiden Sumame)	en/
Maryland	0 0 0	ToB	JOHN E COI	ATES			HAGES	L. Rok	BINSON	CONTES
Man	2 should and Mar Is marks raumatic		19a. Informent's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Si	reet and Number or R	urei Route Number,	City or Town, Sta	te, Zip Code)
	1 and Haalth em 27		20a. Method of Disposition	HINGION	53'// Piaca of Dispos	ition (Name	EN/IA COURT	MEST, 419	DER MARL DU 20c. Location - City	20110-20774
nor	Pages nent of int: If its iry or o		1 Burial 2 Cremation 3 □ 4 Donetlon 5 Other (Specify	Removel from State	cemetery, crem	atory or other	place)	Aug 17 9	SILITION	ALA
Baltimore	permit. Pages 1 a Department of Har Important: If item any Injury or othe		21. Signeture of Funerei Service Licen	70.	47/41NG/C	Name end A	dress of Facility	ATNEYS	FINIERAL	- HOME
m	Depa Impo any Ir		John M. Latu	y J. cc03	48 38	131 GE	ORGIA AV	DE ZOO	//	
	4 3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the dea	th. Do not ente		1 . 4 /			Approximate Interval Between
ì	Physician /Medicai			1	,					Onset and Death
	Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a. BRALL	N 7	UMO	R			MONTH
		ner		Due to (or as a conseq	uence of):				
	tificata be assecuted ig physician and as the burial-transit	edical Examiner	Sequentially list conditions,	b. Due to (or as e conseq	uenca of):				
60,	be axi ician a burial	al E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C						
68760,	ficata phys as tha	edlo	resulting in death) Last	Due to (or as a consequ	ence of):				
Вох		Physician/M		d			-			
O.	s deat	sick	Part ti. Other significant conditions co	intributing to deeth but not re	sulting In the un	derlying caus	e given in Part I.	23b. Dld to	bacco use contrib	outs to the cause of death?
P.O.	ires that the death cer signed by the attendid d be detached for usa							1 🗆 Ye	8 2 No 3	Probably 4 Unknown
Records,	requires that the death cer been signed by the attendir should be datached for usa	d by				-		24a. Wes ar	autonou 2	4b. Were autopsy findings
CO	> 10 00	Completed						perform		avellable prior to completion of cause
	ysician: The law is certificate has b director, page 2 s	ошо						1 ☐ Ye	s 212No	of death?
a	lan: T	BeC	25. Was case referred to medical				26. Place of De	ath (Check only one		10 165 20 NO
>	hysic his ce al dire	2	10100		ER/Outpetient	3□ DOA	Other: 4 Nursing F	lome 5 ☐ Reside	nca 6 Other (5	Specify)
Division of Vital	Aftar t funan	:uol	27. Manner of Deeth 1 Maturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describe ho	w injury occurred	
181	Attanc r daatl cctor: by tha	fleat	2 Accident investigation 3 Suicide 8 Could not be determined	28e. Placa of Injury - At h	nome, ferm, stre		1 ☐ Yes 2 ☐ No	28f. Location (Str	eet and Number o	r Rural Route Number,
á	s afta	Certification:	4 Homicide	building, etc. (Speci	ify)			City or Town	Stete)	,
	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director After this certification and the funeral director, completely filled in by the funeral director,	edical	Correct Offiny Z Medical Exami	sician: To the best of my kno iner: On the besis of examine	owledge, death	occurred at the	e time, date and place	, and due to the ca	use(s) end manne	r as stated.
	thin 2 thin 2 or the l	Med	29b. Signeture end title of certains	and manner stated.			ense number		d. Dete signed (M	
	F ≥ F 8		1/ 1/3	(M.D.		5	41970	5	- // ~ (99
	4	-	30. Name end address of person who c	ompleted cause of death (Ite	m 23e) (Type, F	Print)			10	//
			N. TAVAL	KOLI PC	14 0	CHEVI	ERLY N	(D. 20	785	
	Sta Registra		31. Date filed (Month, Day, Year) AUG 19 199	32. Registrer's Sign	ature 4	100				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Veer **Physician** LEIGH HICKMAN RICHARD AUG 15 1999 6:00 AM /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Yeer Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 6. Sex **Funeral** 1∑M 2□ F Yrs Director 330-22-1321 April 17,1928 Illinois Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code Funeral 1601 Ingram Terrace 20906 USA permil. Pages 1 and 2 should be filled within 72 hours after deal Department of Health and Mental Hygiene. Important: if flam 27 is marked other is any injury or other traumants. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Married 1945-1 ☐ Yes 2월 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1967 White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 MIS Manager Bechtel Power 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) Be Alvyn R. Hickman 2 Ethel M. Crockett 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Eva Ruth Hickman (wife) 1601 Ingram Terrace Silver Spring, Maryland 20906 20b. Piece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta Dete 1 ☐ Burlat 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 8/17/99 Alexandria, Virginia 21. Signature of Funeral Service Libenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Peof. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finei disease or condition resulting in deeth) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Due to (or as e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events Due to (or es a consequenca of) Physician/Medical Due to (or es a consequence of): resulting In deeth) Last Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 N Yes 2 No 3 Probably 4 Unknown þ 24a. Was an eutopsy performed? 24b. Were eutopsy findings evellable prior to completion of cause of death? Completed 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 2☑ No 1X Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 - Homicide 29e. Certifler 🖒 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signatura and title of certif 29c. License number 29d. Dete signed (Month, Dey, Year) 97-01873 (NC) 8/14 199 Dai NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

State Registrar 30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

JOSEPH J. SPOSATO, LT, MC, USNR

31. Dete filed (Month, Dey, Year)

the Maryland

WITH

death

r 28a-f sh notified

r than "natural", or items 23s or the Medical Examiner must be r

attending physician and for use as the burial-transit

signed by the a

page 2 s

funeral director,

certificate

After this

after death. Director: Aft

24 hours e Hospital

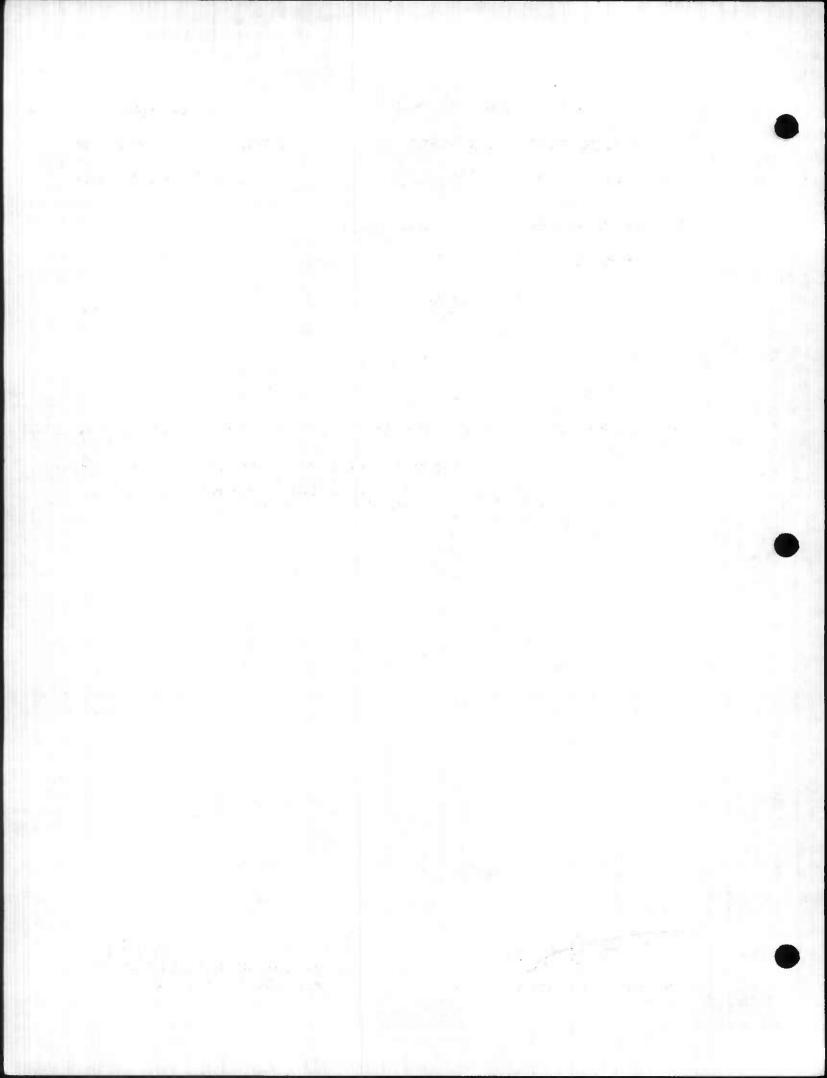
To the within 2

10+1

or Attending Physician:

that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Tima of Death Day Month

4b. City, Town, or Location of Death

Chevy Chase

12, 1999

4c. County of Death

Montgomery

August

3:00 p.m.

1. Decedent's Name (First, Middle, Last) **Physician** Wendell /Medical 4a Fecility Name (If not institution, give street and number) Examiner 3616 Chevy Chase Lake Drive, #4 5. Sociel Security Number **Funeral** 364-07-8252 Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at page. Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

Rockwood

physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificata be executed

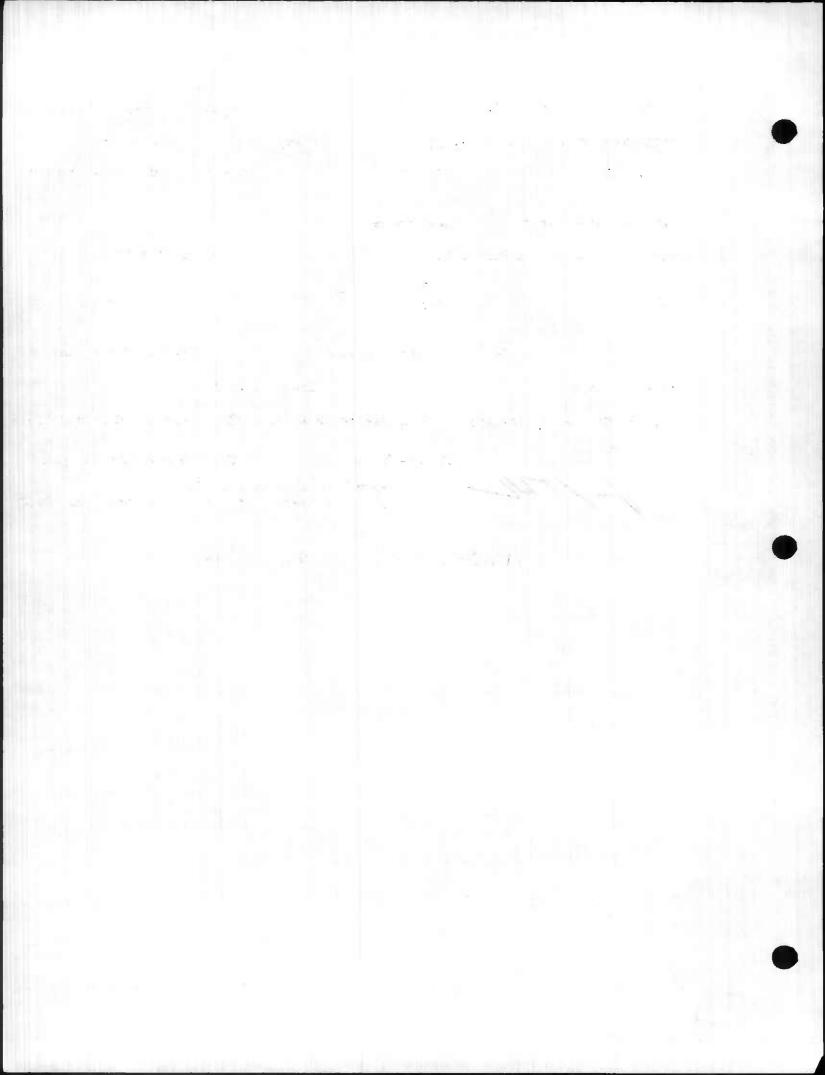
within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending pl
completely filled in by the funeral director, page 2 should be detached for use as it

Division of Vital Records, P.O. Box 68760,

	5. Sociel Security Number	6. Sex	7. Age (In yrs. I		If Under		If Under		8. Date of Bi	rth	9. Birthplace	(State or Foreign
	364-07-8252	1₽M 2□F	91	Yrs.	Months	Deys	Hours	Min.	March March	3, 1908	Country)	
	Usual Residence of Decedent						1		21012 011	3, 1700	, iabbac.	
	10a. Stete 10b. County		10c. City	, Town or Lo	cation						10d. ir	side City Limits
ctor	Maryland Montg	omery	Chev	y Cha	se						1	□Yes 2No
ire	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Country?	
Funeral Director	3613 Chevy Chas				208						States	
une	11. Marital Status	Armod Fo	edent Ever in U.S	5. 13.	Was Dece If Yes, spe	dent of H cify Cube	ispenic Orl en, Mexicar	lgin? (Spo n, Puerto	ecify Yes or N Rican, etc.)	0- 14. Ra Bla	ce - American In ick, White, etc.	dian,
	1 Never Married 2 Merr	If Vas Gi	2 No 194		1 ☐ Yes	2 X No	Specify:			Speci	fv:	
d by	3 ☑ Widowed 4 ☐ Divorced	Year or D	ates: 196	3							White	
ete	15. Decedan (Specify only higher	t's Education st grade completed)		16a. Deced (Give	kind of wo	rk done o	du <i>rina</i> mos	t of work	ing	16b. Kind of E	lusinass/Industry	1
Completed	Elemantary/Secondary (0-12)	Collaga (*			oo noru 1 Off		•			United	States	Navv
	17. Father's Name (First, Middle,			Mava	1 011	.1001		er's Name	e /First Middle	e, Maiden Suma		Navy
Be	Harvey P. Holt								Carter		,	
P				101 10 11							Out. 7/2 Out	-1
	19a. Informant's Name/Ralations		011)	1111						ber, City or Town		
	Harry A. Caleva	s (attorn					Road	1, 5-				and 2081
	20a. Method of Disposition 1 ☐ Buriel 2 X Cremation	3 Demoval from		ace of Dispo emetary, crar	natory or o	ma or other plac	;e)	i	Data	20c. Location	- City or Town, S	State
	4 Donation 5 Other (S		Che	sapeal	ke Cr	emat	ory	8	3-13-99	Beltsv	ille, Ma	ryland
	21. Signature of Fungral Service	Licenson /	63-57	22	. Name ar	nd Addres	ss of Facili	ty	· T			
	1 /-	/ My							ices, F		36 1	1 00010
	23a. Part1. Enter the disease, or	complications that of	ausad tha daath								Marylai	nd 20910
	shock, or haart failure. List	only one cause on e	each line.				9,				Inte	roximata rval Between et and Death
	Immediata Causa (Final	n 1	1	1	1-	_	1-		/-	n 1-	1	0 10 -
	disease or condition rasulting in daath)	a. A	neroac	clero	tic	Ca	raic	va	scuja	r dise	ase y	eans
100			Dua to (or	as a consec	quance of):						/	
ine		b									į.	
кап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or	as a consec	quenca of):						1	
E .	cause. Enter Underlying Cause (Disease or Injury	,										
dica	that Initiated evants resulting in death) Last	V	Due to (or	as a conseq	uence of):							
Me		L.										
by Physician/Medical Examiner		d										
sici	Part II. Other significant condition	ns contributing to de	eath but not resu	iting in the u	nderlying o	cause giv	en in Part	l.	23b. Dic	tobacco use c	ontribute to the	cause of death?
th'									1	Yes 2 000	3 Probably	4 Unknown
y F												
ed t										s an autopsy		utopsy findings
									pen	formed?		e prior to tion of cause
Complet												11
S	25 M									Yes 2 XNo	1 □ Ye	ZINO
Be	25. Was casa refarrad to medical examiner?	Hospital:				Oth	er.		h (Check only			
To	1) Yas 2 No	10		ER/Outpatier		JA	4LIN	ursing Ho			her (Specify)	
O	1 Natural 5 ☐ Pendin	9	th, Day Year)	28b. Time of Injury		28c. Injur Wor			260. Describe	how injury occu	med	
cat	2 Accident investig 3 Suicide 6 Could				М	םי	Yes 2□					
E	4 Homicide determ	inad 200, Place	of Injury - At hoing, etc. (Specify	me, farm, str	eet, factor	y, office				(Street and Num own, State)	ber or Rural Ro	ute Number,
Ce								-				
Medical Certification:	(Check only 2 Medical	g Physician: To the Examinar: On the b										
Ped	one)	end man	ner stated.									
2	29b. Signature and title of certifier	10-		1.0	29	c. Licens	e number	10		29d. Dete sign	ed (Month, Day,	Year)
	Patricia	K. lom	sko,	MD		DS	141	6		Hugu	st B	1999
		/	,/								. ///	1
	30. Nama end addrass of parson	who completed caus	sa of daath (Itam	23a) (Type.	Print)	11	10 1	2 11		·V	,	
	30. Nama end addrass of parson		sa of daath (Itam	23a) (Type,	Print)	lle	Pikp	#2	48 P	octuill	e MD	2085/
ite	30. Nama end addrass of person Path [CI d] 31. Date filed (Month, Day, Year)	Tomsko, 1	sa of daath (Itam	10 Ro	CKVI	lle_	Pike	#3	48, R	ockvill	e, mD	20852
te ar	Patricia [] 31. Date filed (Month, Day, Year)	Tomsko, 1	MD, 1114	10 Ro	CKVI	lle_	Pike	#3	148, R	Pockvill	le, MD	2085/

Sta Registrar



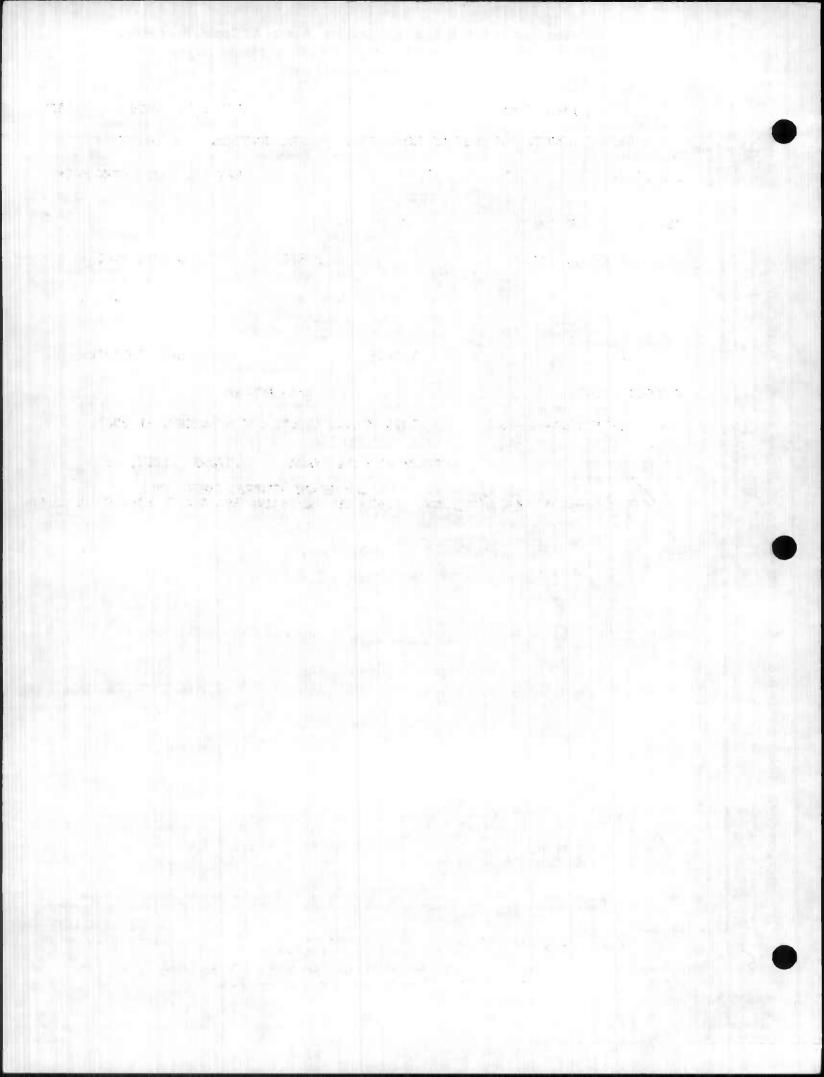
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Day **Physician** AUGUST 15, 1999 6:15PM CHIYOKO HOSOYA /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not Institution, give street and number) **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Yrs. 73 MAY 25, 1926 JAPAN Director 213-13-9217 Usuel Residence of Decedent the Maryland worls 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MONTGOMERY GERMANTOWN MARYLAND Direct 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number with 21313 GLENDEVOR COURT 20876 UNITED STATES Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 2 should be filled within 72 hours efter of and Mental Hygiene. Is marked other than "natural", or item 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ASTAN þ 31 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) SELF EMPLOYED TAILOR 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) MOTOHEI HOSOYA NAKE HOSOYA 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum pace. 21313 GLENDEVOR COURT GERMANTOWN, MD 20876 LARRY NISHIDA/SON-IN-LAW 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 NBurlel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 08/17/99 NORBECK MEMORIAL PARK OLNEY, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME, INC. Di My Win Thom MD 20904 11800 NEW HAMPSHIRE AVE SILVER SPRING, 23a. Part 1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician MULTIPLE ZYEARS Immediate Ceuse (Finel disease or condition resulting in death) MYELOMA /Medical Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest physicien and the burial-tran Due to (or es e consequence of): Box 68760. certificate be Physician/Medical Due to (or as a consequence of): 88 use 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by I 1 Ysa 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en eutopsy Completed page 2 has 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes aN No OL 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) funeral 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Neturel 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) end menner stated. edicai 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number MARYLAND AUGUST 15, 1999 042452 30. Name and address of printing who completed cause of deeth (Item 23e) (Type, Print) 20. CHMA RATAGOPAZ, M.D. PHILIP DRING, #327, OCNEY, MD 20832 18111, PRINCE 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State

DHMH 16 Ray 6/95

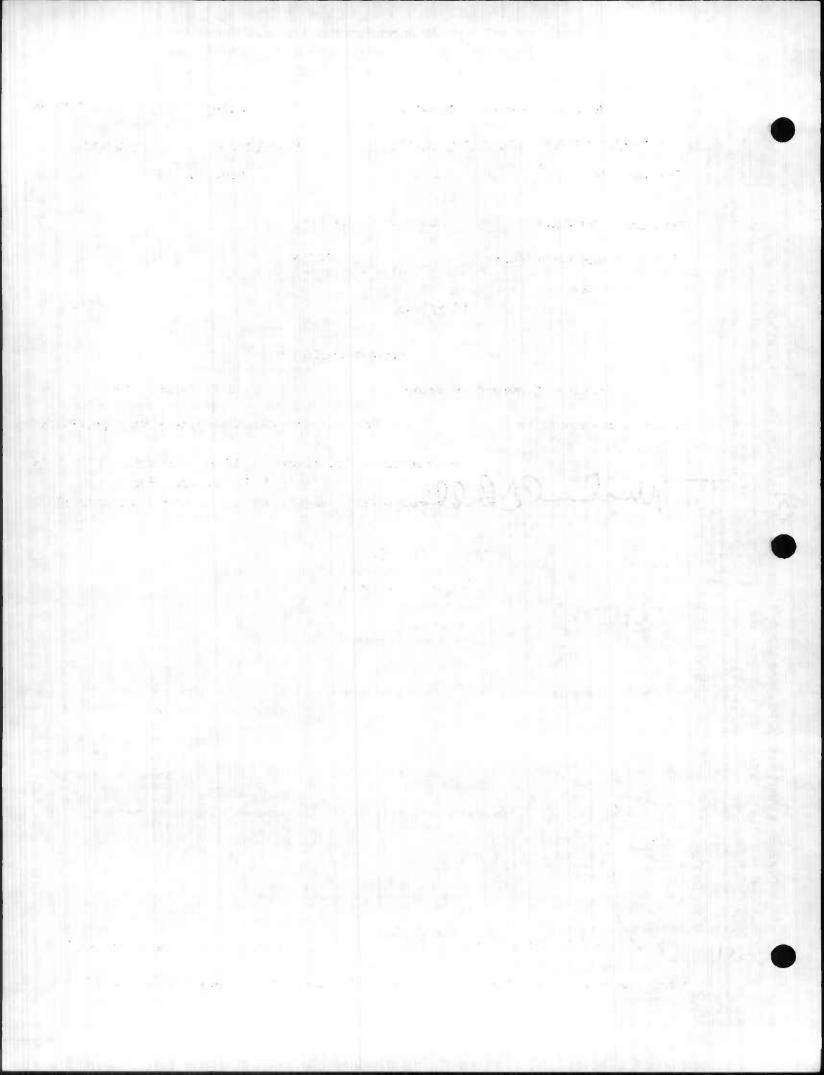
Registrar

AUG 1 7 1999



State of Maryland / Department of Health and Mental Hygiene

	Certificate of De	eath	Reg.	No.	6	160	0
	Decedent's Nema (First, Middle, Last)		Dete of Deeth Month	Dev	Yaar	3. Tima of	Deeth
sician edical	Robert Wayne Houston		igust	11,	1999	7:55	PM
eçicai miner	4a Facility Neme (If not institution, give street and number) 4b. C	City, Town, or Locati	on of Death	4c. County	of Deeth		
ral tor	288-18-5788 15 M 2 F 74 Yrs. Months Days H	Hours Min.	LE Dete of Birth (Month, Dey, Yo			ERY eca (Stete ony) 110	r Foreigr
	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10	d. Insida Ci	ity Limits
*						1 ☐ Yes	
Directo	Maryland Montgomery Montgomery Village	е	1				
늄	10e. Street and Number 10f. Zip Code		10g	. Citizen of V	vnat Count	ry?	
Ē	19116 Brooke Grove Court 2088			United			
Funeral	11. Marital Status 12. Wes Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispar If Yes, specify Cuben, M	anic Origin? (Specify Mexican, Puerto Rici	Yes or No- an, etc.)		e - America k, White, e		
	1 Navar Married 2 Married 1 Navar Married 1 N	Specify:		Specify	:		
d by	3 □ Wildowed 4 □ Divorced Year or Detas: 1944/1945				Wh	ite	
ete	15. Decedent's Education 16e. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done durin	on ing most of working	16	b. Kind of Bu	usiness/Ind	ustry	
ğ	Elementery/Secondary (0-12) Collega (1-4or 5+)						
Completed	5+ Nuclear Engine			N.R.C			
Be (17. Father's Name (First, Middla, Last)	3. Mother's Neme (Fi	irst, Middle, Ma	iden Sumem	10)		
0	Erskine Crawford Houston	1	May Cu	lver	Thoma	as	
-	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and	d Number or Rurel R	oute Number, C	ity or Town,	State, Zip	Code)	
	Betty B. Houston/Wife 19116 Brooke Gro	ove Ct 1	Montgom	erv Vi	11age	.MD.2	0886
	20e Method of Disposition 20b. Place of Disposition (Name of			c. Location -			
	1 ☐ Buriel 2 ☑Cremetion 3 ☐Removal from Stete cemetery, cremetory or other place)		0.400				
	4 □ Donetion 5 □ Other (Specify) Metropolitan Cremato		2/99 A1	exand:	ria,	Virgi	nia_
	22. Neme end Address of	DeVo	1 Funer	al Hom	ne		
	Dullan 10 East Deer	Park Dr	Coith	erchu	ra M	D 20:	977
	23e. Fert1. Enter the disease, or complications that caused tha daeth. Do not enter the mode of dying, st shock, or heart feliure. List only one cause on each line.	such es cardiec or re	spiretory arrest	,	rg, m	Approximat	e
٠.	shock, or heart feilure. List only one ceuse on each line.					Intervel Bet Onset and	
	Immediate Ceuse (Finel						
	Immediate Ceuse (Finel disease or condition resulting in deeth) 9.						
_	Due to (or es e consequence of):						
Examiner	ANECOCIONIA						
(an	Sequentially list conditions, Due to (or es e consequence of):						
ì	if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events Due to (or es e consequence of):						
3	thet initiated events rasulting in death) Lest Due to (or es e consequence of):						
Medical	Tasuring in death) Lest						
	d						
0	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in	in Port I	23b. Did tobe	ICCO HEE CO	ntribute to	the cause	of death
Physician/	Part II. Other eighticant conditions continuum g to deem but not resulting in the underlying cause given in	ar Pett I.				ebly 4	
			1 🗆 Yes	2/5 No	9 L 100	aury 4	JIIKIIUW
d by			24a. Was an	nethness	24b We	re autopsy	findings
Completed			performe		ave	npletion of	to
p						death?	N. B. Carlot
000			1□ Yes	201 No	10	Yes 28	No.
BeC	25. Was case referred to medical 26	6. Place of Death (C	Check only one)		1		
0	examiner? / Hospital C	4□ Nursing Home		e siloe	er (Soone	d	
-		A STATE OF THE PARTY OF THE PAR	t Describe how	Constitution	المداملت المستوجليون		
o	DSNatural S Pending (Month, Pay Year) Injury Work?	s 2□No		O WASHINE	Mary		
Certification:	2 Cl Accident / Wrongelon	-11.F-1480005	Location (Stre	at and North	Mir or Phys	Doube No.	nher
ŧ	4 Homicide determined 28e. Place of Injury - At home, tarm, stelet, factory, office building, etc. (Specify)	281	City or Town,	State)	our or return	- / House Profit	Harris .
Ce							
cal	29a. Certifier ASC Certifying Physician: To the best of my knowledge, death occurred at the time, of Check only 12 Medical Examiner: On the basis of examination and/or levestigation, in my opinion.						44
edicai	(Check only 2 Medical Examiner: On the basis of examination and/or idvestigation, in my opinions)	on, oears occurred.	at the time, dan	and place,	27G 306 ID	270 CRUSS	79
ž	29b. Signature and fitte of certifier , A 1 A 29c. License nu	number	290	i. Date signe	id (Month,	Day, Year)	
		1280		0.	12	18-	
		1400		0-		1 1	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	2.0	1	1 200	7/	
	Anush Dadgar, M.D., 13219 Executive Park Terrace	e, Germant	cown, Ma	arylan	a 208	1/4	
ite	31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture						
istrar	AHG 16 1999 Server G. Sould	/					



State of Maryland / Department of Health and Mental Hygiene

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	4		Com	

Physician /Medical Examiner	
Funeral Director	

Hummer

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: if fleen 27 is marked other than "netural", or fleers 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified and place. Baltimore, Maryland 21215-0020

> **Physician** /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death cartificate be axecuted within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

4a Facility Name (If not 5. Social Security Numb 5. Social Security Numb 5. Social Security Numb 5. Social Security Numb 10a. State 10b Maryland Pr 10a. Street and Number 5. O23 Nantuc 11. Marital Status 1 Never Married 3 Widowed 4 15. (Specify o	Eugene institution, give 502 or 6. Se 12 edent . County ince Ge	Hummer street and number 23 Nantuc M 2DF 7.1	Cket Ro Age (In yrs. Is 59		If Under 1 Year Months Days			Day 12 4c. County Prince	ce Ge	3. Time of Dec 03:50 eorge's lace (State or Fo
4a Facility Name (If not 5. Social Security Numb 578-52-1909 Usual Residence of Dec 10a. State 108 Maryland Pr 10e. Street and Number 5023 Nantuc 11. Marital Status 1 Never Married 3 Widowed 4	institution, give 502 er 6. Se 12 er 6. Se 12 er	street and number 23 Nantuc 23 Nantuc 5 M 20 F 7.1	Cket Ro Age (In yrs. Is 59	est birthday) Yrs.	Months Days	College	ocation of Death	4c. County Prince	of Deeth CE GE 9. Birthpi	eorge's
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Maryland Pr 10e. Street and Number 5023 Nantuc 11. Marital Status 1 Never Married 3 Widowed 4	ince Ge			, Town or Lo	cation					
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5023 Nantuc 11. Marital Status 1 Never Married 3 Widowed 4 Specify of		nd.		lege P	ark					1 ☐ Yes 2 🛣
11. Marital Status 1 Never Married 3 Widowed 4 15. (Specify of		h			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
1 Never Married 3 Widowed 4 15. (Specify of		u			2074	+0		U.S.A.		
3 Widowed 4 15.		12. Was Deceder Armed Force:	nt Ever in U.S	5. 13. Y	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yea or No-	14. Raci	e - America k, White,	
(Specify o		1 ☐ Yes 2 5 If Yes, Give Year or Dates	No		1 ☐ Yes 2 🖾 No		, radari, die.,	Specify		ite
	Decedent's Edu			16a. Decer	dent's Usual Occu	pation		16b. Kind of Bu	siness/Inc	dustry
Elementary/Secondar	ly highest grad	le completed) College (1-4o	v 54)	(Give life. (kind of work done DO NOT use retin	e during most of work ed)	ting			
12	, (0 .2)	4			Computer	Genius		U.S	Goy	Vt.
17. Father's Name (First	Middle, Last)					18. Mother's Nam	e (First, Middle,			
Eugene Lewi	s Humme:	r				Quida	a Teague	e		
19a. Informant's Name/						et and Number or Rui	ral Route Numbe	r, City or Town,		
Kathy V. Gr	amling	/ Sister				ale Lane,	Reston,	Virgini	ia 20	191
20a. Method of Dispositi 1 ☐ Burial 2 1 Cr				ace of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location -	City or To	wn, Stete
4 Donation 5			75	nation	Center	18	1/16/99	Chanti	11v.	Virgini.
21. Signature of Funera	Service Licens	00 ///	1020	22	. Name and Addr	ress of Facility				***************************************
1	A.	7//		Mu	rphy Fal	lls Church	Funera	1 Home	**	00016
23a. Part1. Enter the di	sassa or compl	ications that caus	ad the death	Do not ent	or the mode of du	Broad St.,	or respiratory at	rest	va.	22046 Approximate Intervel Between
Sequentially list condition		b	Due to (or	as a conseq	uence of):				1	
Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injurthat initiated events	iate									
Cause (Disease or injur- that initiated events resulting in death) Last	•	C	Due to (or	as a conseq	uence of):					
resonary ar county case	L,									
									1	
Part II. Other significant	conditions cor	ntributing to death	but not resul	lting in the ur	nderlying cause g	iven in Part I.	23b. Did t	obacco una cor	ntributa to	the cause of de
							101	rea 2 No	3 Prot	bably 4 ☐ Unk
							24a. Wes	an autopsy	24b. We	ere autopsy findir
								med?	COI	ailable prior to mpletion of caus
										death?
							1)X(V		1,2	Yes 2□ No
25. Was case referred to examiner?	-	lospital:			0	26. Place of Deal				
1 Yes 2 No 27. Manner of Death		1 Inpa	tient 2 E	ER/Outpetien 28b. Time of	II SLI DOA	4 LI Nursing H	ome 5 XResid			
	Pending investigation	(Month, E	ay Year)	Injury	We	ork? ☐ Yes 2☑No	4 ()			Polic
1 Natural 5	Could not be	28e, Place of I	Injury - At hor	me, farm, str	eet, factory, office		281. Location (S	treet and Numb	er or Rura	het b
1 Natural 5 2 Accident 3 Suicide 6		building,	etc. (Specify))			City or Tow	n, State) 50	23 1	Vantucke
1 Natural 5 2 Accident	determined		-	idence		time data and along	and due to the			
1 Natural 5 2 Accident 3 Suicide 6 4 Nomicide 6 29a. Certifier (Check only 20)	determined Certifying Phys		st of my know of examination			opinion, death occur			and due to	
1 Natural 5 2 Accident 3 Suicide 6 4 OHomicide 6	determined Certifying Phys Medical Examin		st of my know of examination		vestigation, in my		rred at the time, o			the ceuse(s)
1 Natural 5 2 Accident 3 Suicide 6 4/2/Homicide 29a. Certifier (Check only one) 1 1 2 2 2	determined Certifying Phys Medical Examin	ner: On the basis	st of my know of examination		29c. Licen	opinion, death occur	rred at the time, o	date end place,		the ceuse(s)
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1 Natural 2 Accident 3 Suicide 4 Memoricide 29a. Certifier (Check only one) 29b. Signature and title	Certifying Phys Medical Examin of certifier A f person who co	ner: On the basis and manner:	st of my know of examination stated.	On and/or im	29c. Licen Print)	opinion, death occur nse number O.C.M.E.	rred at the time, o	date end place, 29d. Date signer Augus	d (Month,	Day, Year)
1 Natural 2 Accident 3 Suicide 4 Memoricide 29a. Certifier (Check only one) 29b. Signature and title	Certifying Phymidedical Examination of certifier A person who co	ner: On the basis and manner: A 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	st of my know of examination stated.	on and/or im	29c. Licen Print)	opinion, death occur	rred at the time, o	date end place, 29d. Date signer Augus	d (Month,	Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** Mary Freda Irons 1:00pm 1999 August 16 /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not Institution, give street end number) Examiner 7321 Gaither Road Sykesville Carroll If Under 1 Year If Under 24 Hrs. S. Date of Birth (Month, Dey, Year)

Months Deys Hours Min. June 12 1919 7. Age (In yrs. last birthday) 5. Social Security Number 219-42-5251 **Funeral** 1□M 2XF MD Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md Carroll Sykesville tX Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number i 7321 Gaither Road 21784 USA permit. Peges 1 end 2 should be filed within 72 hours after death v Department of Health and Mentel Hyglena. Important: If item 27 is marked other than "natural", or items 23a enty injury or other traumatic event, the Med as Examiner must least. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Oliver O. Keefer Florence Clay Gartrell 19a. Informent's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gloria E. Fitzgerald 1601 Valley Drive Westminster, MD 21157 20b. Place of Disposition (Name of cometery, cremetory or other place)
Lake View Mem. Park 20c. Location - City or Town, State 20a. Method of Disposition Date 8/19/99 Sykesville, MD 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that feaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Physician/Medical Examiner ettending physician end for use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as a consequence of): resulting In death) Last 23b. Did tobacco usa contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 Ho 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peen completion of cause of death? has 1 Yes 2 No 1 Yes 2 10 No certificete Physician: 25. Was case referred to medical exeminer? director Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After t or Attending 5 Pending investigation n 24 hours after death.

• Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospitai 1 (9 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certific 2 41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREIS Stones 245

State Registrar 31. Date filed (Month, Dey, Yeer)

AUG 1 8 1999

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 358 MGUST 4c. County of Death ROBERT DONNELL **JONES** /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, give street and number) Examiner 3849 BARNABAS 3 ROAD All TEMPLE PRINCE GEORGES If Under 24 Hrs. If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Hours 100M 20 F Months Deys 578-68-7133 Director 49 July 3, 1950 DC Usuei Residenca of Decedent the Meryland 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Directo MD Prince Georges Temple Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 3849 St. Barnabas Road, #T3 20746 Funeral United States death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yaer or Dates: 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuben, Mexican, Puarto Ricen, etc.) permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. If item 27 ia marked other then "natural", or ite 1 Nevar Merriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: **Black** Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Administrative Assistant 12th Private Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumama) Be Robert Jones, Sr. Pansy Chandler 19a. Intorment's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Pansy Jones/Mother 3124 Newton Street, N.W., Washington, DC 20018 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) injury or Harmony Memorial Park 8/20/99 Landover, MD 21. Signature of Funeral Servica Licansee 22. Name end Address of Facility Iny R. N. Horton Co. Morticians, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** . HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner buriel-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence ot) and Division of Vital Records, P.O. Box 68760, physiclan that the death certificete be Physician/Medical the Dua to (or es a consequence of): 98 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Or Onknown DIABETES MELLITUS by 8 24b. Were autopsy tindings eveileble prior to completion of cause ot death? 24e. Wes en eutopsy performed? Completed has 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certific director, 25. Wes case reterred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funerel 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Tima of 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 □ No investigetion 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier Medical 🔁 Certifying Physician: To the best of my knowledge, daeth occurred at the time, dete end placa, end due to the cause(s) and manner es stated. (Check only Medicat Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) To the Vithin 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRZ PRIVE, CHEVERLY, MAKYLANU HOSPITAL MARYO F. MO 3001 GOLLE

DHMH 16 Rev 6/95

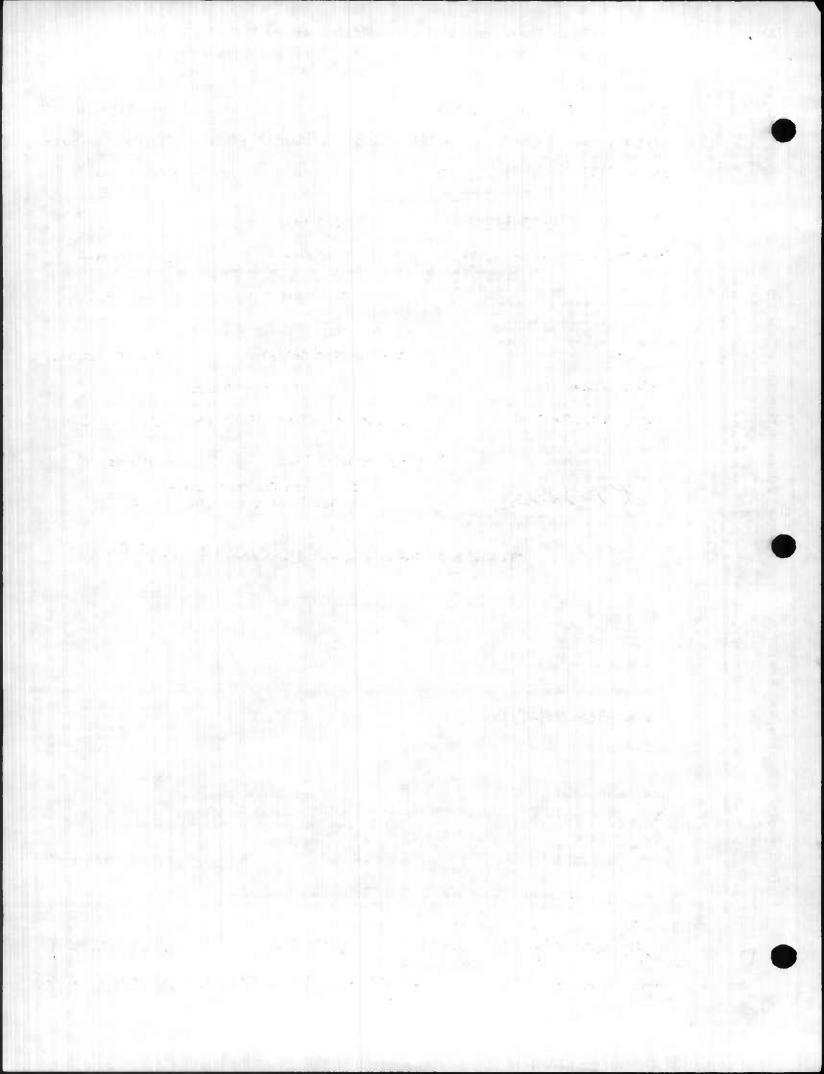
State

Registrar

31. Dete tiled (Month, Day, Year)

AUG 20 1999

32. Registrer's Signeture



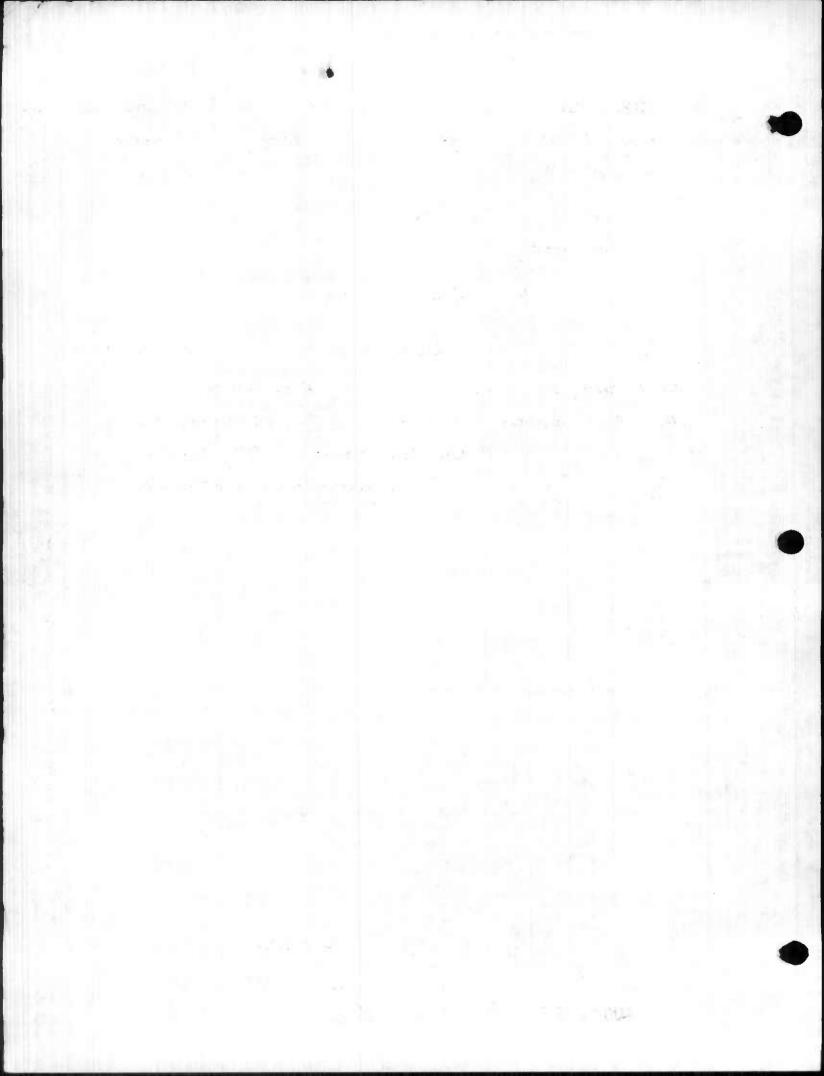
State of Maryland / Department of Health and Mental Hygiene

Certificate ca 'esth 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** ELMER EDWARD JEFFRIES AUGUST 1999 4:32 18 A.M. /Medical 4a. Facility Neme (if not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frostburg Village Nursing Home Frostburg Allegany if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) October 26 1924 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months 1 M M 2□ F Yrs Director 219-14-5229 74 Usual Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinat must be notified at Allegany Frostburg Director 1 Yas 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21532 176 W. First Street USA permit. Pages 1 and 2 should be filed within 72 hours after deeth a Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than "natural", or items 23s any injury or other traumatic event, the Men Funeral 12. Wes Decedent Evar in U.S.
Armed Forces? IWII

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Yaar or Detes: ATMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No þ Army Specify: White 3 ☐ Widowad 4 ☑ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Electronics Merchant Marines 17. Father's Nema (First, Middia, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 2 Joseph Edward Jeffries Alice Sanders 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 46 Jones Mill Road, Wrightstown, NJ 08562 Debbie Hollen daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)
Cumberland Crematory Aug. 19 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cumberland, MD 1999 21. Signature of Funerel Service Licensee 22. Name and Address of Feclity Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD
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Lonaco Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Myo Car deal
Dua to (or es e consequence of): disaese or condition rasulting in deeth) Examiner Examiner Covonany and Due to (or es e confequence of): arling The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertinsion. þ should 24b. Were autopsy findings available prior to complation of causa of deeth? Be Completed 24e. Wes an eutopsy performed? · Occlusio Vasculer page 2 s Disease with Bilatine amputations 2 No 1 □ Yes 2 □ No certificate or Attending Physician: 25. Was cese referred to medical exeminer? director 26. Place of Deeth (Check only one) Other: 4 D Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Deeth 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No ector: A by the f 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MUH (IVA) 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) SL. Sandhir MD Frostburg MD 21532 48 Tarn Terrace, 31. Dete filed (Month, Day, Year) 32. Registrer's Signature AUG 1 9 1999 Lener Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month OCHER Kson 151 4e Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Hospital Baltimore Baltimore County Months Deys Hours Min. September 11, West Virginia 5 Sociei Security Number 7. Aga (In yrs. last birthday) 10 M 20 F Months September 67 Yrs. 234-48-6855 Usuai Rasidenca of Deceden 10a. Stete West 10b Counts 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Fayette Virginia Oak Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 300 Broadway Avenue 25901 of America 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Merital Status Bieck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 XNo Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Service Workers Supervisor 18. Mother's Neme (First, Middla, Maidan Sumema) 17. Fether's Neme (First, Middle, Last) Homer L. Jackson, Sr. Lucy V. Roche 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Susie Saunders Jackson/Wife 300 Broadway Avenue, Oak Hill, West Virginia 25901 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition August Ingram Branch, 1 Buriai 2 ☐ Cremetion 3 ☐ Removei from State Meadow Haven Cemetery 19, 1999 West Virginia 4 Donation 5 Other (Specify) 21. Signeture of Funerei Servica Licensee #M00690 22. Name end Address of Fecility Ritchie and Johnson Funeral Home 6 CNI 748 South Fayette Street, Beckley, West Virginia 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervei Between Onset end Deeth Immediate Cause (Final andio Renal Varaula diseese or condition resulting in death) errosclarulec Due to (or es a consequenca of): Sequentielly list conditions, If eny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2/ JAK 25. Wes case referred to medical 26. Placa of Deeth (Check only one) axaminer Hospitei: 1 ☐ Inpatient 2 ☐ FFVOutpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Menner of Deeth 28a. Deta of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Waturei

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7 is marked other then "natural", or itema 23s or 28s-f shot traumatic event, the Modical Examiner must be notified at

nii. Pages 1 and 2 should be filed within 72 hours efter or sartment of Health and Mentel Hygiena. ortant: If item 27 is marked other than "natural", or ites Injury or other traumatic event, it a Medical Examiner.

permit. Page Department o Important: If i any Injury or

Baltimore, Maryland 21215-0020

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Physician/Medicai þ Completed Be 2 Certification:

2 Accident

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29a. Certifier

4 Homicide

(Check only one)

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31. Date filed (Month, Dey, Yaer) AUG 18 1

Hospital or Attending Physician: 24 hours after deeth. within 2 To the To the 3

State Registrar

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1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, and due to the ceuse(s) and menner as steted 2 iMedical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

6 Could not be determined

1999

29b. Signeture end title of cartifier

meel 30. Heme end eddress of person who completed se of death (Item 23a) (Type, B

28e. Piaca of Injury - At home, farm, straat, factory, office building, etc. (Specify)

1 Yes

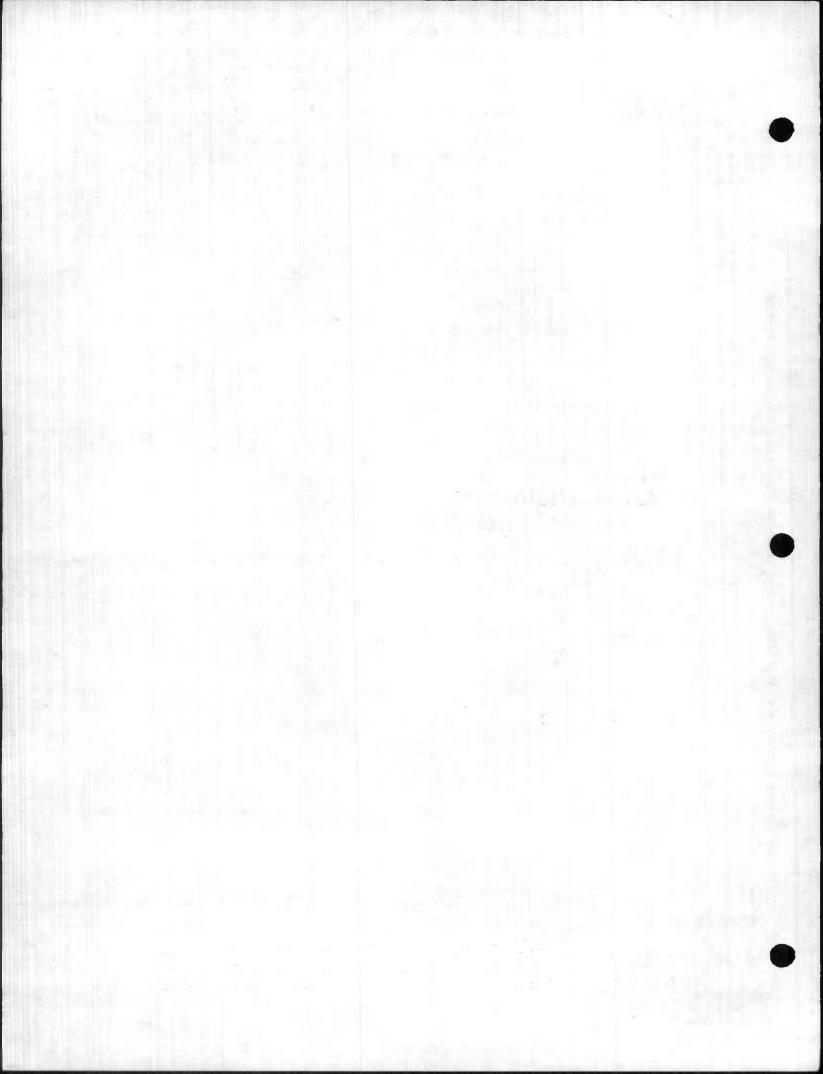
29c. Licansa number

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29d. Dete signed (Month, Day, Year)

28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete)

32. Registrer's Signature ineva



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Glen Edward Aug. 13, 1999 Jarrel1 5:45 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) Aug. 20, 1934 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Days 11XM 20 F Hours Min Months 64 578-42-9480 **Director** Usual Rasidance of Decedani 10a. Siala 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director none none Washington, D.C. 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 5347 Nevada Ave., N.W. 20015 flame 23a USA 12. Was Decedent Ever in U,S.
Armed Forces?

1. Yas 2 No
If Yas, Giva
Year or Dates: UNK Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 X Married "natural", or 1 Yes 2 No Specify: Specify: ď 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Self-Employed Locksmith 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Falhar's Nema (First, Middla, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked off Russell Jarrell Sylvia Pearl McClung 19a, Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Hem 27 Is any Injury or other tra otice. 5347 Nevada Ave., N.W. Wash., DC 20015 Irene Jarrell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Aug. 15, 1 Burial 2 Cramation 3 Ramovel from Stela 4 Donation 5 Other (Specify) Metropolitan Crematory Alex., VA 1999 DeVol Funeral Home 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility 2222 Wisconsin Ave. Washington, D.C. 20007 1 Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each irre. Approximata Intarval Between Onset end Death **Physician** Immediala Causa (Final disaasa or condition resulting in death) /Medical SEPTIC SHOCK. 14 DAYS Examiner Examine MEDIASTINITIS physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enlar Underlying Cause (Disease or Injury Due to (or as a consequence of) ESOPHA GEAL RUPTURE (PERFORATION) Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown - CHRONIC OBSTRUCTIVE PULMONARY RENAL FAILURE þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? DISEASE DIABETES MELLITUS has 1 Yes 2 No 1 Yes at No HYPE RTENSION Be 25. Was casa referred to medical examinar? 26. Place of Death (Check only one) 1 Vas 2 No Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Panding invastigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of tnjury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funerel DI completely filled it 1) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifiar (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D35941 AUGUST 14 1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) PURAN P. MATHUR. ROCKVILLE 50 W. EDMONSTON DR. 31. Data filed (Month Pay Year) AUG 17 32. Registrar's Signature State

Registrar **DHMH 16 Ray 6/95**

Baltimore, Maryland 21215-0020

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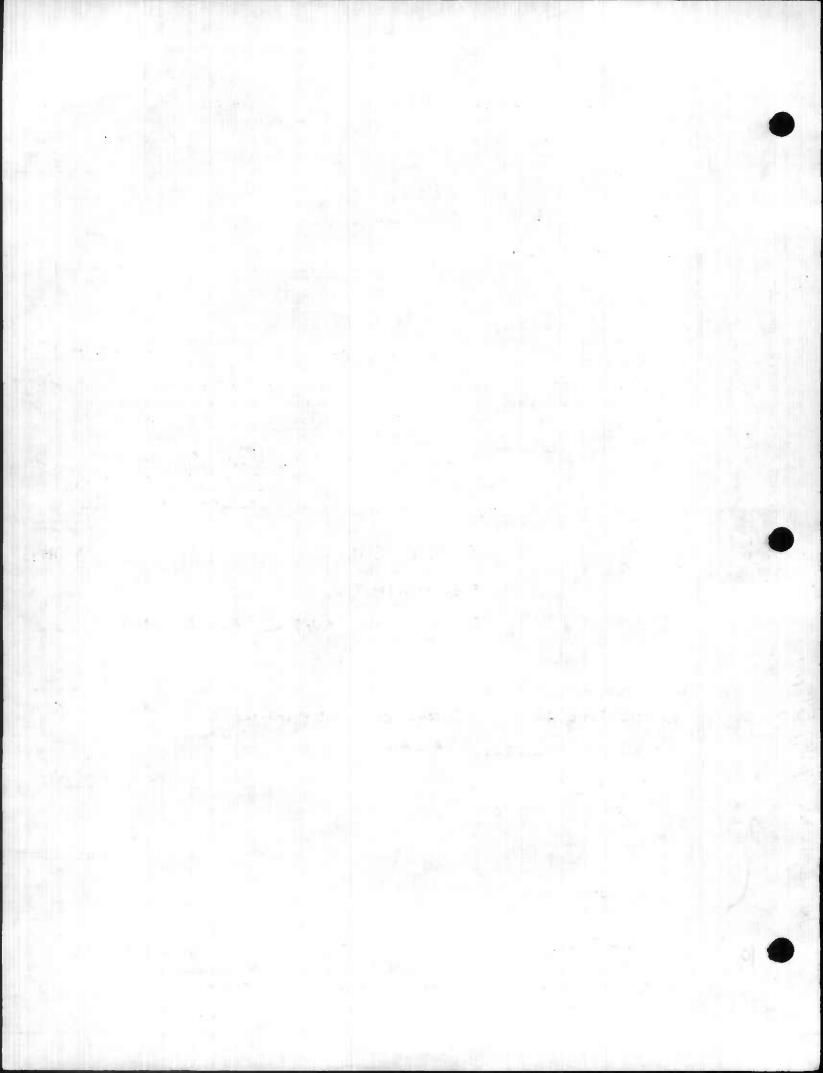
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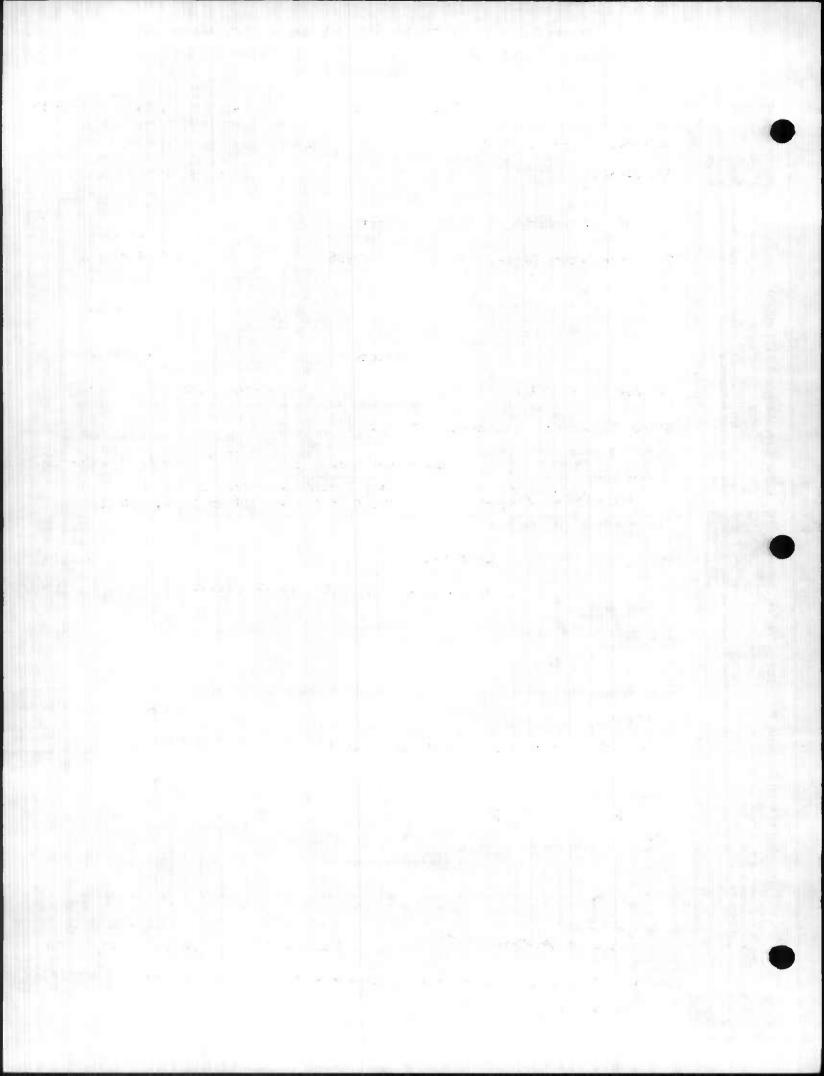
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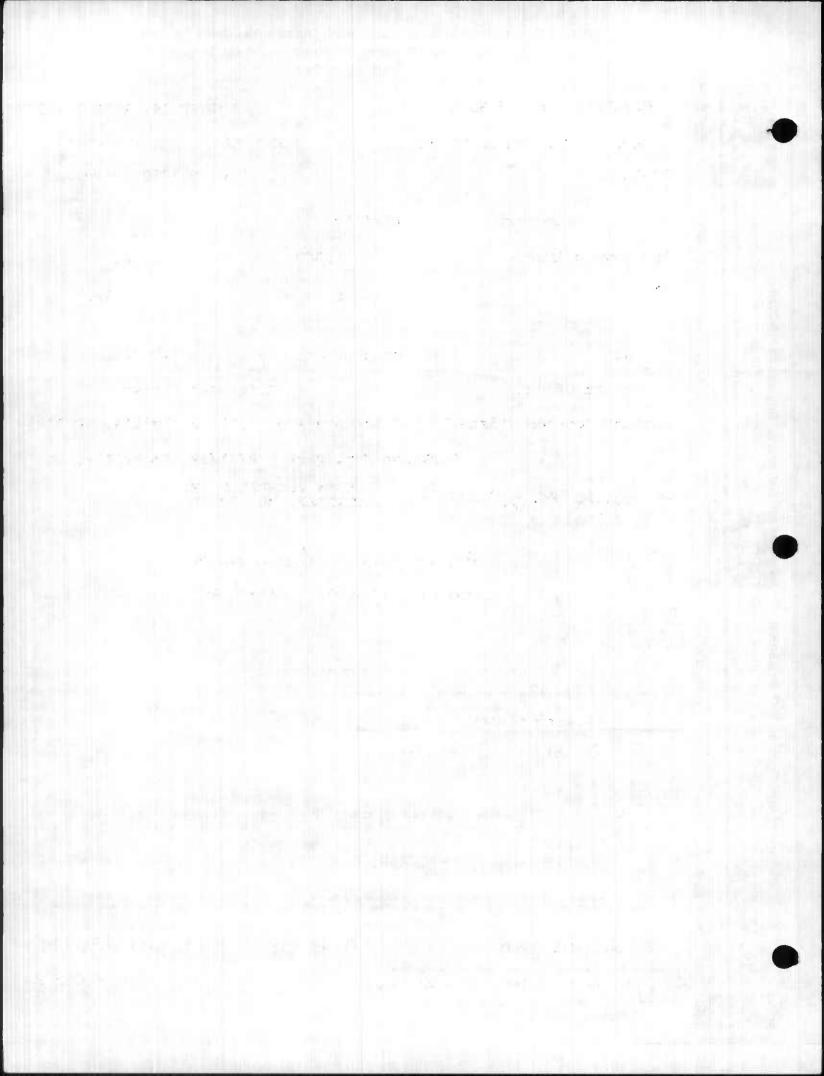
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	/Medical	de Carilla Manne Mane Inchiniste ele		.0110 00		4b. City, Town, or Loc		4c. County		
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_	- market	Montgomery Gener		s. last birthday)	If Under 1 Year	01ney If Under 24 Hrs.	8. Date of Birth	Monts		
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	land land	10a. State 10b. County	10c.	City, Town or Loca	ation				10	0d. Inside City Limits
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20	. 0	3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1[☐ Yes 2 No	Specify:		Specify		
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Maryland		19a. Informant's Name/Relationship	Type, Print)	19b. Mailing	Address (Street	t and Number or Rura	i Houte Number	, City or Town,	Stete, Zip	Code)
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0	or of	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		. Place of Disposi cemetery, crema	atory or other pla			20c. Location -	City or 10	wn, State
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Saltimore,	permit. Page Depertment of Importent: If I any Injury or once.	21. Signature of Funeral Service Lice		22.	Name end Addre	ess of Facility	n D	Α.		
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J	Physician	shock, or heart failure. List only	one cause on each line.						1	Interval Between Onset end Death
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	orificate be asscuted ing physician and es the burial-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as e consequ	ence of):					
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387	icata be physicials tha bun	resulting in deeth) Last	Due to	(or es a conseque	ence of):					
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o.	by the a	Pert II. Other significant conditions	contributing to death but not r	esulting in the und	derlying cause gi	iven in Part I.				o the cause of death?
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of Vital Records,	The law requires that the death certificate be assocuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examinations.								045 141	are subseque fin dia se
orc	The law require sate has been si page 2 should	Arteriosch	notic COR	eh wow	Ascula	n Disters	24e. Was a perform		ava	ere autopsy findings ailable prior to empletion of cause
ec	awr 2 sb	11/2/07-5	100110 001			13.			of	death?
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ta		25. Was case referred to medical				26. Place of Death	(Check only or	10)		
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0	Physer this seral d		28a. Dete of Injury (Month, Day Year)	28b. Time of	28c. Inju	iry at	28d. Describe h	ow injury occur	red	
Division	or Attending after death. Director: After I in by the fune	1 ☑Naturei 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2□No				
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á	rs after death. al Director: After ted in by the funers Centification:	4 Homicide	building, etc. (Spe	city)			City or Town	i, Siale)		
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	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	(Check only 2 Medical Examone)	miner: On the basis of exami and manner steted.	nation and/or inve	estigation, in my	opinion, deeth occurre	ed at the time, d	ate and placa,	and due fo	the cause(s)
	within 2 To the comple	29b. Signature and title of cartifier			29c. Licen	se number	2	9d. Date signe	d (Month,	Day, Year)
	10 /2	Jane a	Dom Wy		Do	4543	A	4.6411	- 19	1598
	10(2)									
		30. Name and address of person who	completed cause of death (If	em 23a) (Type, P	rint)	RLD BLVD	. SIL V	enspri	n3 1	np 20901
		James A. Rossi			June or)			
	State	31. Date filed (Month, Day, Year) AUG 20 199	32. Registrar's Sig		1					
	Registrar	TOU > 0 133	Julian	D.	Ann V					



State of Maryland / Department of Health and Mental Hygiene

			Certificate	e of Death		Reg. No.						
	1. Decedent's Name (First, Middle, La	ist)			2. Dete of De Month	eath Day	3. Time of Death					
Physician	CATHERINE	M. JOHNSON			AUGU		1999 14:45 H					
/Medical Examiner	4a Facility Nama (If not institution, give	re street end number)		4b. City, Town	, or Location of Deer							
Examiner	SHADY GROVE	ADVENTIST H	OSPITAL.	ROC	KVILLE	MON	TGOMERY					
Funeral		Sax 7. Age (In yrs.	lest birthday) If Undar	1 Year If Under 24	Hrs. 8. Date of Bi		Birthplaca (State or Foreign Country)					
Director	213-16-2079	1□ M 2XF 8:	Months	Days Hours			Maryland					
	Usual Residence of Decedent		DCC . Z	2,1210	магутани							
/and	10a. Stata 10b. County	10c. City			10d. Inside City Limits							
Men. Tor	MD Monto	omery	Rockvill	0			13€ Yes 2 No					
Unter death with the Menyland ritems 23s or 28s-f show instrumed be notified at Funeral Director	10e. Street and Number	, 1	10f. Zip			10g. Citizen of V	What Country?					
with with	203 Dawson Av	70.0110				TT 0						
s 23		12. Was Decedant Evar in U,	S 13 Was Decede	20850	2 (Specify Ves or N	U.S.	A . e · American Indian,					
	11. Marital Status	Armad Forces?	If Yes, speci	ent of Hispenic Origin fy Cuban, Mexicen, F	uerto Ricen, etc.)	Bied	ck, White, etc.					
1 00 0	3 Widowed 4 Divorced	1 ☐ Yes ② No If Yes, Give Year or Detes:	1 ☐ Yes 2	No Specify:		Specify	: Black					
"natural", or he			40- Davidania Have	Occupation		10h Kind of B	John and Barbusta					
ed within 72 ho ygiane. or than "natura it, the Medical	15. Decedent's E (Specify only highest gro	ducetion ada completed)	16e. Decedent's Usual (Give kind of work life. DO NOT use	k done during most of	f working	160. King of bi	usiness/industry					
od within od within or than "re than "r	Elementary/Secondary (0-12)	College (1-4or 5+)				School						
al Hygiane. other than vent, than the Be Comp	6th		Houseke		Alexander of the Adiabatic							
ind 2 should be filed the and Mental Hyg. 77 is marked other traumatic event. To Be C	17. Father's Name (First, Middle, Last				Neme (First, Middle							
should be of Mental marked o matic ev	Herbert Off	utt			Elizabet							
ges 1 and 2 should to f Health and Mer if item 27 is marke or other traumatic	19a. Informant's Name/Reletionship (19b. Mailing Address									
	Dorothy Johns						lle, MD 20850					
of Haalth Item 27	20e. Method of Disposition		lace of Disposition (Nem emetery, cremetory or of	e of her piece)	Date	20c. Location -	City or Town, State					
Z :: 9 0	1 XBuriel 2 Cremation 3 4 Donetion 5 Other (Special		cklawn Mem	. Park	8/21/9	9 Rock	ville, MD					
permit. Pege Department of Important: If any Injury or once.	21. Signature of Funerel Service Lice	ns6e) /	22. Name end	Address of Fecility								
Deparation and in the same of	21. Signature of Funerel Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850											
	23a Part I Enter the Peace or com	unlikations that coursed the deat					Approximete					
NEW WILLIAM	23a. Part1. Enter the sease, or com shock, or heart fure. List only	one ceuse on each line.	i. Do not enter the mode	or dying, addit os od	roled of respiratory t),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	interval Between Onsat end Death					
Physician /Medical	Immediate Cause /Final			0								
Examiner	Immediate Cause (Final disease or condition rasulting in deeth) e. Aspiration Preumonia Due to (or as a consequence of): b. Cerebrovascular Aceident											
COLUMN TWO IS NOT THE OWNER.												
si di		b. Cere	provascu	Lar 7	taiden	t						
axecuted in end ital-transit	Sequentially list conditions,	Due to (o	r as a consequence of):									
ouria ouria	Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events	C										
fliceta be assected gibhysician and st the burial-transit edical Examir	that Initiated events resulting in deeth) Last	Due to (o	r as e consequence of):									
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v requires that the death cerbeen signed by the attending should be deteched for use letted by Physician/N		u	-				i					
as that the death or general by the attent be deteched for unby Physician	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying ce	euse given in Part I.	23b. Dio	tobacco uae co	ntribute to the cause of death?					
that the ed by th deteche	11	16.00			1	Yes 2000	3 ☐ Probably 4 ☐ Unknow					
bed by	tlyper	tensioni					T					
The law requires sete hes been sign page 2 should be	01	tension etes Mell	1.1			s en eutopsy ormed?	24b. Were autopsy findings available prior to					
ne law requires to the second be sec	Diab	ries iriel	LITUS				complation of causa of death?					
he law te hes age 2					10	Yes 2 No	1 ☐ Yas 2 ☐ No					
ifficet or. p	25. Was cese referred to medical			26 Place o	Death (Check only	/-						
centification in Be	examinar?	Hospitel:	55/0-1-1-1-1 2 ⁻	Othors			and (Canada)					
Physician: T this certificat ral director, pr	1 ☐ Yes 2 No 27, Manner of Deeth	1 X npatient 2 28a. Dete of Injury	ER/Outpatient 3☐ DO 28b. Time of	A A Nuis	ing Home 5 ☐ Res	how injury occur						
Aftar funa ion	1 ⊠Netural 5 ☐ Pending	(Month, Dey Year)	Injury	Bc. Injury et Work? 1 ☐ Yes 2 ☐ No								
or Attending effer death. Director: After I in by the funa ertification	2 Accident investigation 3 Suicida 6 Could not be					(Creat and Numb	ber or Rural Route Number,					
or At free collines in by	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	oma, farm, streat, factory	, опісе	City or To	wn, Stete)	per or nural noute Number,					
To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funeral Director: After this centificate he complately filled in by the funeral director, page Medical Certification: To Be Com	,											
tosp 4 hox fune ely fi	(Check only 2 Medical Example 12	nysician: To the best of my kno miner: On the basis of exemine										
the the point of t	one)	end manner stated.										
To the within To the complex c	29b. Signature and title of certifier		29c.	License number		29d. Dete signe	d (Month, Dey, Year)					
3	6. Gupta	mp	D	46398		rugus	+ 15, 1999					
	30. Name and address of person who		23e) (Type, Print)	11	0		d (Month, Dey, Year) + 15, 1999 D 20852					
	G. Gupta, MD.	13 congressions	I lane.	# 409	Kockvi	He, M	0 20852					
State	31. Date filed (Month, Dey, Year)	32/Registrer's Signa	ture 4									
Registrar	AUG 1 7 19	199 Jeneura	p. pp	als								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death

1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth August 14, 1999 Physician Lillian E. Jones /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner Manor Care - Bethesda Montgomery Bethesda If Undar 24 Hrs. 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months 1□ M 2√ F Days Hours Min 578-07-9199 83 Yrs **Director** Sept 16, 1915 Washington, DC Usual Residence of Dacedani with the Maryland r 28a-f show 10a. Steta 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 is marked other than "naturel", or items 23s or traumstic avent, the Medical Examiner must be re-2306 Greenery Lane, Apt. 201 20910 United States Funeral death 12. Was Dacedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) pemit. Pagas 1 and 2 should be filed within 72 hours aftar 1 Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or iter any injury or other traumatic avent, the Medical Examinations. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Bookkeeper Automotive 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Andrew T. Hornig Alice Maud Chism 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Edward S. Jones 7020 Statendam Court, McLean, Virginia 22101 (son) 20b. Placa of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 🛱 Cramation 3 ☐ Ramoval from State 8-16-99 Beltsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory 22. Nama and Addrass of Facility
Rapp Funeral Services, P.A. 21. Signatura of Funaral Sarvice Licensaa arol Q 933 Gist Avenue, Silver Spring, Maryland 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Final · CHRONIC OBSTRUCTUR haymon 106 disaasa or conditior rasulting in deeth) **Examiner** Dua to (or as a consequanca of) Examiner

Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disease or injury that initieted avants resulting in daath) Last

TONCO CHOQUETE Due to (or as a consequence of) Dua to (or as e consaquança of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performad?

24b. Wara autopsy findings eveileble prior to completion of cause of death?

Approximate Intarval Batween Onset and Death

1:00 AM

Birthplaca (Stata or Foraign Country)

10d. Insida City Limits 1 ☐ Yas 2 No

2 ENO 1 Yas 26. Piaca of Daath (Check only one)

1 Yes 2 No

25. Wes case referred to medical axaminar? 1 Yas 2 No 27. Manner of Deat

5 Pending

investigation B ☐ Could not be

1 [Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Place of thjuty - At home, farm, stree building, etc. (Specify)

Injury at Work? 1 Yes 2 DNo

Other: Nursing Home 5 - Residence 5 - Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Flural Floute Number, City or Town, State)

29a. Certified (Check only one) 29b. Signature and

1)SNatural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of experimention and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of exe and manner stated/ 29c, License number

H51280

29d. Date signed (Month, Day, Year)

30. Name end address of person who complated causa of deeth (Item 23a) (Type, Print)

13219 EXECUTION PARK TRACRARIZ CIRROLLING MU 20874 ALUSH DADOTARIDO 31. Data filed (Month, Day, Year)

State Registrar

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Aftar this funaral

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Physician/Medical

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Certification:

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Box 68760.

P.O.

Division of Vital Records.

or Attanding Physician:

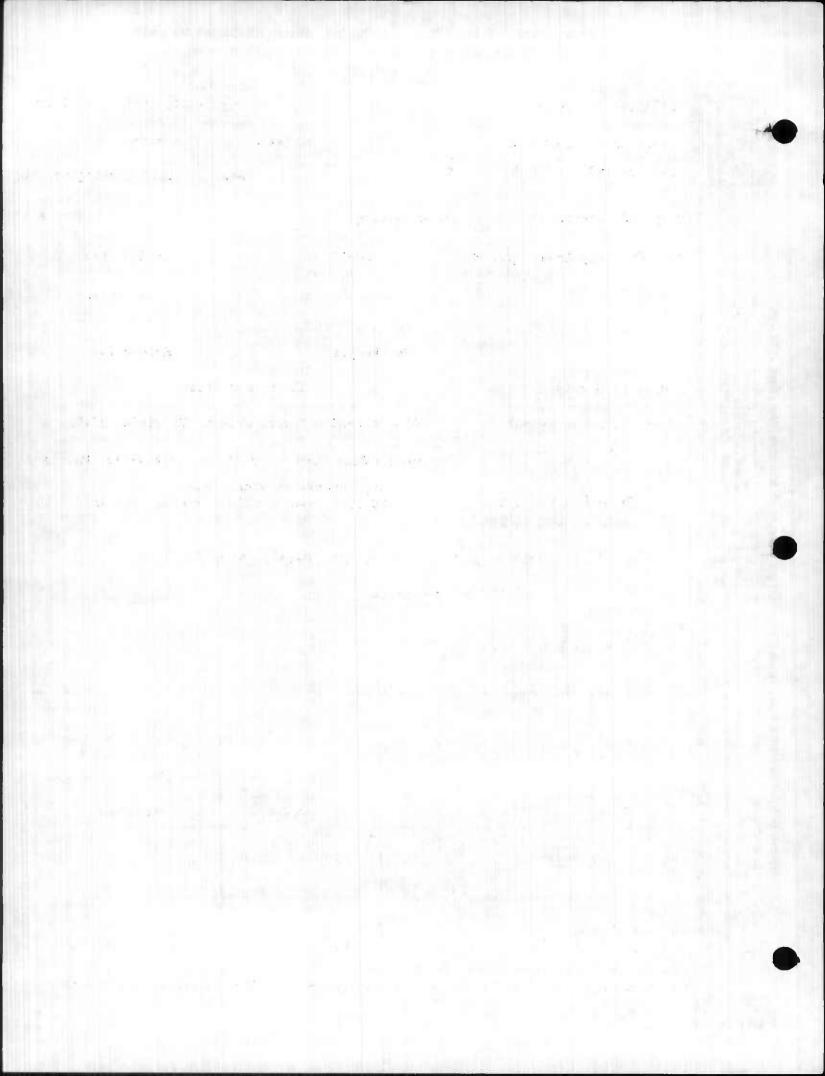
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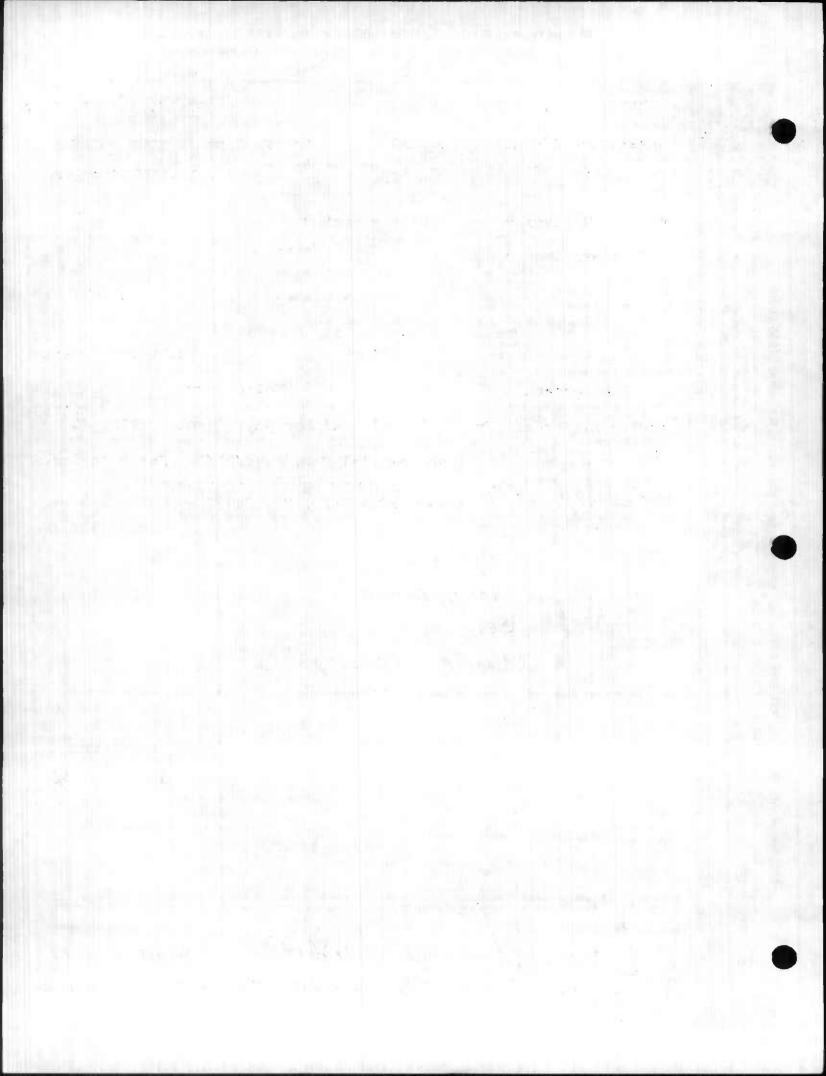
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that the death cartificate be

32. Registrer's Signature



	1.	Decedent's Name	e (First, Middle, Las	st)		Cer	invall	O OI	Death	2. Date of D			3. Time of Death	
hysician /Medical		MAUI	RICE R.	JORDA		SR			th City Town or	AUGU:		-	11:10 A	M
xaminer ineral ector	5.		ngton Acoumber 6.8	e street and number, dventist ex QM 20F	Hos	last birthday)	If Under Months		Takoma If Under 24 Hr. Hours Mir	a Park s. 8. Date of B	Mirth Dey, Year)	ONTGOM 9. Birthp Coun 931 Ma	lace (State or Foreign	
ž m	-	a. State	10b. County		10c. Cit	y, Town or Loc	ation					1	0d. Inside City Limits	
to de		MD	Montg	omery		Silve	er S	pri	ng				1⊠Yes 2□No	
finer must be notified at	10	e. Street and Nur 107 Ge	^{mber} eneva Av	enue			10f. Zip		20910			n of What Coun	lry?	
by Fune	•	. Marital Status 1 [™] Never Marri 3 [™] Widowed	ied 2 Married 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 1 If Yes, Give Year or Dates:	?		Vas Deced Yes, spec		lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Black, White,	etc.	
		(Specification)	15. Decedent's Ed cify only highest gre endary (0-12)	College (1-4or 2 Yrs	5+)		ent's Usua kind of woi DO NOT us Cler		ation during most of wi d)	orking		of Business/Inc		
BeC		. Father's Name	(First, Middle, Last)						18. Mother's Na	ame (First, Midd				
10			ee Jorda			_				len Ber				
Fraum			ame/Relationship (1										Code 20748	
important; it tem 2/18 merked other train instured any injury or other traumatic event, the Medical once. To Be Completed		a. Method of Disp	position	Removel from State		Place of Disposementary, cram h Memo	sition (Nen etory or o	ne of ther pla		Date 8/21/9	20c. Loca	ntion - City or To		
any injury once.		1 E	neral Service Light Market Light he disease, or comp rt failbre. List only	ofications that cause one cause on each I	d the deet	en Ro	OCKV	ILL	ss of Fecility FUNERA E, MD ng, such as cardi	20850		•	Approximete Interval Between	
sician edical miner	di	nmediate Ceuse (seese or conditio sulting in death)	(Final n	a. Hy									Onset and Death	
hed for use as the burial-transit		equentially list co any, leading to in use. Enter Unde suse (Diseese or at initiated events suiting in deeth) I		b. ARI c. SEI, d. MOR	Z U /	r as a consequ		iT	· y					
d for use	Ps	ut II. Other elonif	licent conditions o	ontributing to death I						23h Df	d tobacco u	se contribute to	the cause of death'	?
y Physician/M		at ii. Other argim		onthoday to death t	30(110(103	and the distance of the distan	idenying o	auso gri	TOTAL TOTAL		Yes 2			
sete has been signed page 2 should be det						·					as an autops dormed?	av	ere autopsy findings ailable prior to mpletion of cause death?	
Con										10	Yes 2/1	No 1[Yes 200No	
Be C		. Wes case refer examiner?		Hospitel:				Oth	10 <i>L</i> .	eath (Check only				_
completely filled in by the funeral director, page Medical Certification: To Be Com		1 X Yes 2 Menner of Deet 1 X Natural 2 Accident	h 5 Pending Investigation	28a. Date of Inj (Month, De	ury	28b. Time of Injury		8c. Inju	4LI Nursing	Home 5 Re			у)	
led in by the funera Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of In building, e	ijury - At h tc. <i>(Specil</i>	ome, ferm, stre	et, factory	, office			(Street end own, Stete)	Number or Rura	al Route Number,	
completely filled in by the Medical Certifical	L	Pa. Certifier (Check only one)	2 Medical Exam	ysician: To the best niner: On the basis and manner s	of examina		estigation,	, in my c	ppinion, death oc		e, date end p	elece, and due to	o the cause(s)	
E S	29	b. Signature and	title of certifier	-//				00	se number			signed (Month,		
	30	. Neme snd addn	guru ess of person who	completed cause of	desth (Iter	M D n 23a) (Type, I	Print)	0)	61+1		AUGU	ST 16,	1999	
State Registrar	31	Dr. LAU . Date filed (Mon	JRENCE	Simon 32. Regist	V,	7600 ature	CARR	2011	AVE.	TAKOMA	PARK	k, Md.	20912	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** Curtis G. Ketterman, Sr. 1999 August 09:55 PM 16 /Medical 4e Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 324 Braddock Street, Apt. 12 Allegany Frostburg 8. Data of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 100 M 2□ F 215-14-6207 Yrs 13-Jun-22 Maryland Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If fem 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumstic event, the Wades Essentian must be notified as 1 Yes 2 No Director Maryland **Allegany** Frostburg 10e. Street and Number 324 Braddock Street 10f. Zip Code 10g. Citizen of What Country? 21532-Funeral U.S.A. Apt. 12 12. Wes Decedent Ever in U,S.
Amed Forces?
1 M Yes 2 □ No
If Yes, Give
Yeer or Detas: WWI 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 11. Meritel Stetus 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2D No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) minister church ministry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Harrison Ketterman Amanda Van Meter 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Ketterman 324 Braddock Street Frostburg 21532-Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State Frostburg Memorial Park 19-Aug-99 Frostburg, Maryland 21. Signeture of Funeral Service Licen 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 oku 234 Part. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, mock, or heart feilura. List only one cause on each lina. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Finel disease or condition resulting in deeth) 5 month /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be assecuted the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760. Due to (or as a consequence of) detached for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? diseare page 2 should be detact, Voutsicular 20 No 3 Probably 4 Unknown oronary arten Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1cand 2 No 2/4/No certificate 1 Yes 1 Yes Division of Vital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only ona) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Patural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No Investigation € Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicida 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to tha cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) Shalin MD 30. Name and addrass of person who completed causa of death (from 23e) (Type, Print) Huma Shakil, M.D., 623 Keni Avenue, Cumberland, Maryland 21502 (14)

State Registrar

31. Date filed (Month, Day, Year)

AUG 2 0 1999

32. Registrar's Signatura

emylorid Allegdiny Flostburg 324 Braddock shoot

Don't Princip Tomo, 37 mat year, troublett, sett 11235

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** 12, AUG. 1999 7:20 PM NORMAN PAUL KEENAN /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner KNOLLWOOD MANOR NURSING HOME MILLERSVILLE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days ₩ M 2□ F Yrs. 213-42-9979 Director 29,1944 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if then "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6038 42nd AVE. #A 20781 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forcas?

1 Yes 2 No
If Yas, Give
Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 MAINTENANCE MAN F.A.A. permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy any portant: if Nem 27 is marked othy any Injury or other traumatic event pages. 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fethar's Name (First, Middle, Last) Be 0 LEE KEENAN MARY MORGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ANGELA K. KEENAN/WIFE SAME AS ITEM 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from Stata FT. LINCOLN CEMETERY 8/17/99 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MD. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility MOO091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner 2 astas Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last and Box 68760 Physician/Medical ua to (or as a consequence of) P.O. Part It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yee 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Wara autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? 2 0 No 1 Yas 2 No Be 25. Was cese raferred to medicel axaminer?
1 Yas 2 No 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 De Natural 2 Accident Attending 5 Pending death. Investigation 1 Yas 2 No after death Diractor: 6 Could not be determined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 24 hours aft Funeral Di-letely filled in To the Hospital of within 24 hours a To the Funeral D 29a. Certifian (s) and manner es steted. completely (Check only one) 2 | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License numbar 29d. Date signed (Month, Day, Year) who completed ceuse of death (Item 23a) (Type, Print) *304 Severna Park, MD, 21146 MIDI D. 474 J 32. Registrar's Signatura Junges Hole Loome 31. Date filed (Month, Day, Year)
AUG 16 State 1999

Registrar

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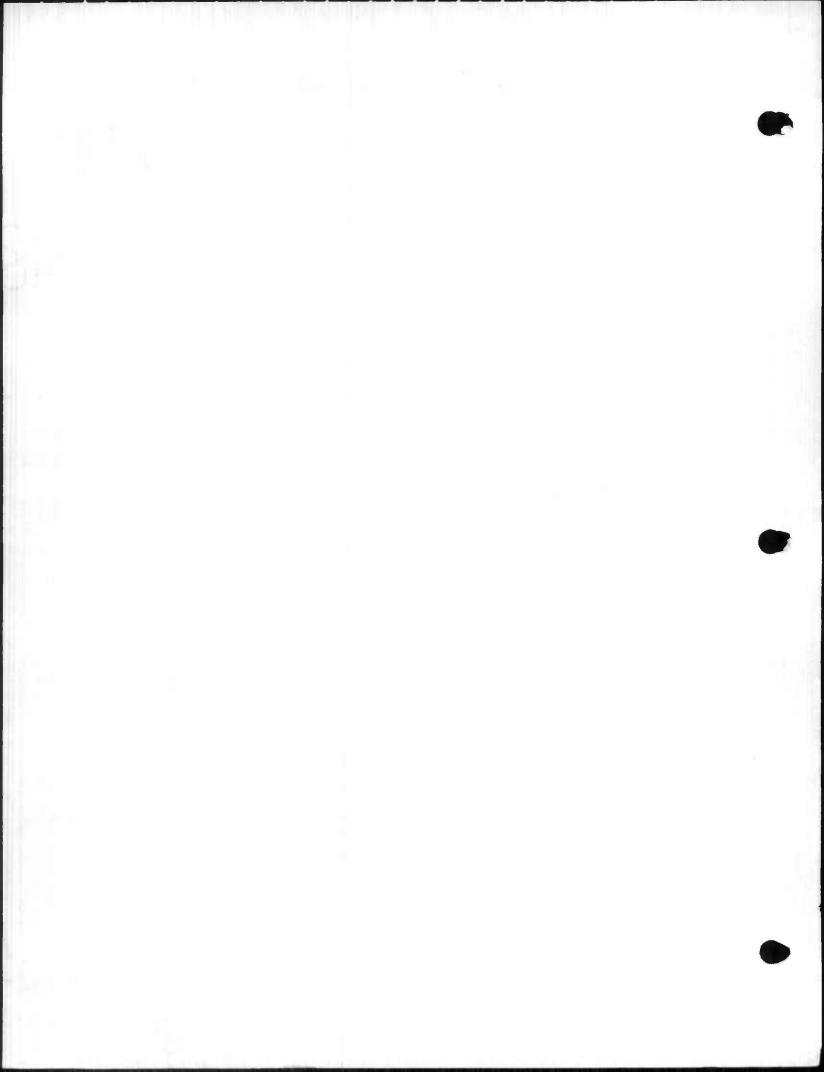
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	TIEGISTAAA				-niii	ICALE	· UF	DEA	111	R	EG. NO.			
	1. DECEDENT'S NAME (FIRST, Abrah	/	Kren	initz	er					2. DATE OF C	DEATH DA	× .	YEAR O	3. TIME OF DEATH 3: 15 A M
	4. SOCIAL SECURITY NUMBER 469-32-/		5. SEX 1 M 2 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF B (Month, Day	(, Year)	クフ	Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not in	stitution, give stre	net and number)			9b. CITY,	TOWN (OR LOCATI	ON OF DEA		0-0	9c. COU	NTY OF OE	
CTOR	COLLEGE VIEW		R			FREI	DERI	CK				FRE	DERIC	K
DIRECTOR	MD	FREDER	ICK		FRE	y, town o DERIC	R LOCAT	TION						10d. INSIDE CITY LIMITS? YES 2 \(\text{NO} \) NO
FUNERAL	100. STREET AND NUMBER 622 ANGELWIN	NG LA						2170				10g. CIT		HAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo	Married	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	MED IO	1 1	yes, sp	ecify Cuba	OF HISPANI in, Mexican Specify:	C ORIGIN? (Sp , Puerto Ricen	ecify Yes , atc.)	or No—	14. RACE Black, Specify	White, etc.
	15. DEC (Specify only	EDENT'S EDUCA	ATION ompleted)	16e, DE	CEDENT'S	USUAL OC	CUPATIO	ON at of working	20	16b. KINS	OF BUS	INESS/INC	DUSTRY	
COMPLET	Elementary/Secondary (0		College (1-4 or 5 +	life.	RINT	se retired.)		01 01 1101/11	, ,	US	GO'	VERN	MENT	
0	17. FATHER'S NAME (First, M.							16. MOTI	HER'S NAM	E (First, Middle	, Msiden :	Surname)		
BE	Usher Kre		r					C1.	ara	Gutman	1			
5	Daniel Krer		So							lerick				
	20a. METHOD OF DISPOSITI 1 ◯ Buriel 2 ◯ Crematio 4 ◯ Donation 5 ◯ Other	n 3 □/Nemo	al from State	20b. PLACE	AND DATE O	OF DISPOSI	TION/Na	me of		8/16	20c. LOC		City or Tow	rn, State
	21. BIGNATURE OF FUNERAL	1	NSEE		1, 1121									EL, INC
	the course	110	Sen	a-		11	70	ROCK	VILLE	PIKE,	, RO	CKVII	LLE,	MD 20852
	26. PART I. Enter the di shock, or hi IMMEDIATE CAUSE (Fin disease or condition resulting in death)	sert fallure. Li	at only one caus	e on each line							or respi	ratory an		Approximate Interval Between Onset and Death
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events rasulting in death) LAST Onest and Death Bruin Onest and Death													
IEDICAL	PART II. Other algnifice	onditional		death but not r			derlylng	cause (given in P		WAS AN PERFOR			WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
2 2	DID TOBACCO U	SE CONTRI	BUTE TO CAL	JSE OF DEA	TH YE	S 🗆 N	10 E	UNC	ERTAIN					1 NES 2 NO
SIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL				TH (Check o	nly one)							
PHYSICIAN:	1 TES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	4 Nurs		• 5 □ Re	eldence 6	☐ Other (Spe	ctty)			
ву Рн		Pending nvestigation	26a. DATE OF I (Month, De		26b, TIMI INJ	E OF URY M		URY AT RK? 'ES 2		28d. DESCRIB	E HOW IN	IJURY OC	CUREO	
	3 Suicide 6	Could not be letermined	26e. PLACE OF building, a	INJURY — At ho tc. (Specify)	me, ferm, e	treet, tecto	ery, office	1		261. LOCATION City or You	(Street ar	nd Number	or Rural Ro	ute Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERT 2 MEDI	IFYING PHYSICI	AN: To the beat of n	ny knowledge, de amination end/or i	ath occurre	nd at the ti	ne, data xinion, d	and place,	, and due to	o the cause(a) ma, data and p	and man	ner se stat	ed,	and manner as stated.
B	29b. SIGNATURE AND TITLE	OF CERTIFIER	John.	a di				29c. LICE	NSE NUME	IER 7		29d. DAT	E SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUST	OSO W.		Print) Vri		0 (4	7	1	. /	111	7-11
	31. DATE FILED (Month, Day 1	7 1999	32. REGISTRAR	'S SIGNATURE	4	1		32		Fred	eri	CK	14/	11105
	71001 2	1 1000			J.	apa	Ks							Ohmen to be the
														DHMH-16 Rev 1/89



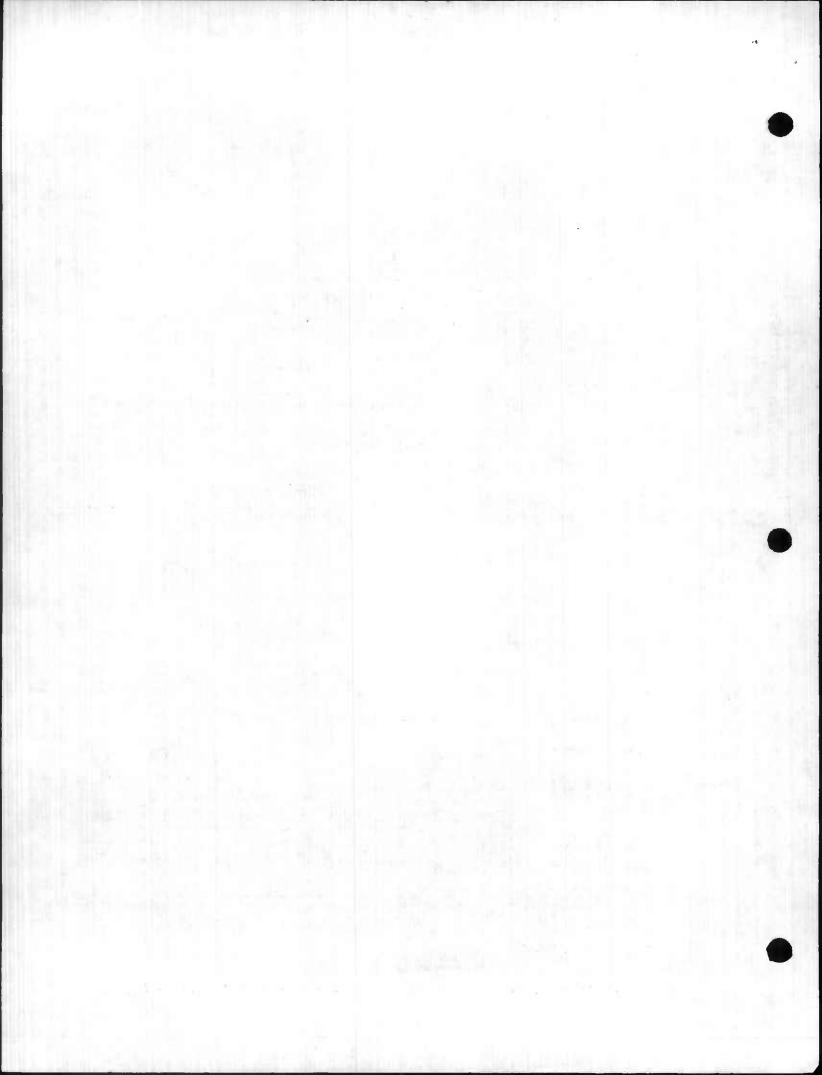
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

•	Certificate of Death	Reg. No.
Physician	1. Decedent's Neme (First, Middle, Last) DOROTHY K. LUCHS	2. Date of Deeth Month Day Year AUGUST 10, 1999 05:20 a
/Medical Examiner		r Location of Death 4c. County of Death
AL		Frederick Calvert
Funeral Director	5. Social Security Number 578-09-4767 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 87 Yrs. 7. Age (In yrs. last birthday) 87 Wonths Days Hours Min	
Mend Mend	10e. State 10b. County 10c. City, Town or Location	10d. Inside City Limi
Man	Maryland Calvert Dunkirk	1 ½ Yes 2□1
h with the	10e. Street and Number 10f. Zip Code 20754	10g. Citizen of What Country? U.S.A
d 21215-0020 filed within 72 hours efter death with the Maryland Hygiene. Hygiene 13a or 28a-f ahow not, the Medical Examiner must be notified at the Medical Examiner must be notified as Completed by Funeral Director	11. Marital Status 12. Was Decedenf Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puel If Yes, Specify: 1 Yes 2 No Specify:	
72 ho	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of wo	16b. Kind of Business/Industry
aryland 21215-002 should be filed within 72 hours and Mentel Hygiene, marked other than "natural, imatic event, the Medical Exe To Be Completed by	Elementary/Secondery (0-12) College (1-4or 5+)	
Co Co Co	2 Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Na	Medical Office ame (First, Middle, Maiden Surname)
Maryland 212 d 2 should be filed with the and Mental Hygiens, This marked other than traumetic event, that To Be Comp	The state of the s	lda Seibold
laryla 2 should end Meni is marked surretic		Rural Route Number, City or Town, State, Zip Code)
Md 2 strike er trau		628 N. Bethesda, MD 20852
nore, Maryland 21215-0 ages 1 and 2 should be filed within 72 he int of Health and Mentel Hygiene. I: If Item 27 1s marked other than "natur y or other traumatic event, the Medical To Be Completed	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete 20c. Location - City or Town, State
Baltimore, Mai permit. Pages 1 and 2 st Department of Health and Important: if frem 27 is n any Injury or other treun once.	21. Signature of Funerel Service Licansee 22. Name and Address of Facility Joseph Gawler's So	8/13/99 Washington, DC ons INC, 5130 Wisconsin Ave.
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart feilure. List only one cause on each line.	C 20016 ac or respiratory arrest. Approximete
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting In death) ———————————————————————————————————	Onset and Death
. Box 68760, death certificate be executed e attending physicien end nd for use as the bunel-transit sician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequenca of):	
P.O. Box thet the death cent ed by the attendin detached for use	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of deat
S, P.O.	CONGESTIVE HART FAILRE CHRONIC	1 Yes 2 No 3 Probably 4 Unkno
In Records, P.O. Box The law requires that the death cer ate hes been signed by the attendin page 2 should be detached for use Completed by Physician/A	Antmix	24a. Was an autopsy performed? 24b. Were autopsy finding aveilable prior to completion of cause of death?
The la life he sage of the la		1 Yes 2 No 1 Yes 2 No
Vital Rec		eeth (Check only one)
of Vita Physician: this certific eral director,	1 Yes 2 DAW Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Other (Specify)
C 5 5 5 5	27. Manner of Death 1 Infatural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28b. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divisio To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fa Medical Certificati		ce, and due to fhe cause(s) and manner as stated.
othe othe omple	29b. Signature apartition of confider 29c. License number	29d. Date signed (Month, Day, Year)
F ≯ F 8	1 (the H 9/age) w D2635	
γ	30. Name and and reson who completed cause of deeth (Item 238) (Type, Print)	
	Dr. John Weigel, M.D. Prince Frederick,	MD 20678
State Registrar	AUG 16 1999 32. Begistrar's Signature 6. Sports	

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	Decedent's Name (First, Middle						2. Date of De Month	Day	Year	3. Time of Death	
cal	Erminia 4a Facility Name (If not institution		erario			4b. City, Town, or	Augus			4:30pm	
ner			Trumber)								
	Holy Cross Hosp 5. Social Security Number	6. Sex	7. Age (In v	rrs. last birthday	If Under 1 Ye	Silver Si	. R Date of Bi	Montgo		ace (State or Fore	
	212-54-6055	1 □ M 2 1 F	E .	36 Yrs.	Months Da	ys Hours Min	. (Month, D	, 1913	Counti	ry)	
	Usual Residence of Decedent						TOULY 7	, 1713	Italy		
	10a. State 10b. County		10c.	City, Town or I	ocation				10	d. Inside City Lim	
Director	Maryland Montgo	mery	Si	llver Sp	oring					1□Yas 2⊋	
1	10e. Street and Number				10f. Zip Cod	le		10g. Citizen of V	What Count	ry?	
	812 Islington S	treet			20910			USA			
	11. Marital Status		ecedent Ever in Forces?	n U,S. 13	Was Decedent If Yes, specify 0	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No to Rican, etc.)		e - America ck, White, e		
	1 Never Married 2 Man	If Yes,	es 2X No Give		1 ☐ Yes 2 ☐	No Specify:		Specify	Whit	P	
	3€CXWidowed 4 □ Divorced		or Dates:	100 000					of Business/Industry		
non-dimon	(Specify only highe	nt's Education ost grade complete	9d)	(Giv	edent's Usual Oc e kind of work do DO NOT use re	ne during most of wo	rking	160. Kind of Bu	usiness/indl	ustry	
	Elementary/Secondary (0-12)	College	e (1-4or 5+)	Homen				O II			
	17. Father's Name (First, Middle,	Last)		Homei	lakel	18. Mother's Na	me (First, Middle	Own Horr , Maiden Sumam			
-	Unknown Nari					Unknown					
•	19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town,									Code)	
	Mariangela Gazzelli/ Friend 13111 Dauphine Street, Silver								lver Spring, MD 20		
	20a. Method of Disposition	CIII, II		b. Place of Disc	position (Name or other		Date	20c. Location -			
	1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Fort Lin		place)	Aug 16	D	. 1 3/	TD.	
ŀ	21. Signature of Funeral Servige		I		22. Name and Ac	dress of Facility	1999	Brentwo	ood, M	Ш	
	6.	heart	10			J. Collins					
-	23a. Part . Enter the disease, or shock, or heart failure. List	zoomolications the	at caused the d	leath Do not e	00 Univ	ersity Bly	rd. W.,	Silver S	Spring	Approximate	
	Immediate Cause (Final disease or condition resulting in death) a. Septicemia Due to (or as a consequence of): Cholangitis										
		. Chol			equence of):				1	lays	
	Sequentially list conditions,	b. Chol	langitis						1	veeks	
	if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	b. Chol	langitis	S					1		
3	if any, leeding to immediate cause. Enter Underlying	b. <u>Chol</u>	langitis Due to	S	equence of):				1		
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carda comission. To be completed by filly straightfully	rif any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other eignificant conditions are sufficient conditions. The conditions are sufficient conditions are s	c. d. d. cone contributing to cotitis cotitis cotitis liure li Hospital: 128a. Da (M) gation not be inned 28e. Ple builtined 28e. Ple builtined 28e. Ple builting Physician: To the and m	Due to o (or as a consection of conse	equence of): underlying cause ant 3 DOA of 28c. I threet, factory, off the occurred at the investigation, in in	26. Place of De Other: 4 Nursing njury at Work? 1 Yes 2 No ice e time, date and plac ny opinion, death occurrence number	24a. Warperl 24a. Warperl 1 □ auth (Check only Home 5 □ Res 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 □Oth how injury occur (Street and Numburn, State) cause(s) and ma, date end place,	anner as sta	the cause of decably 4 Unkr re autopsy findin illable prior to noletion of cause leath? Yes 2 No Route Number, the cause(s)		
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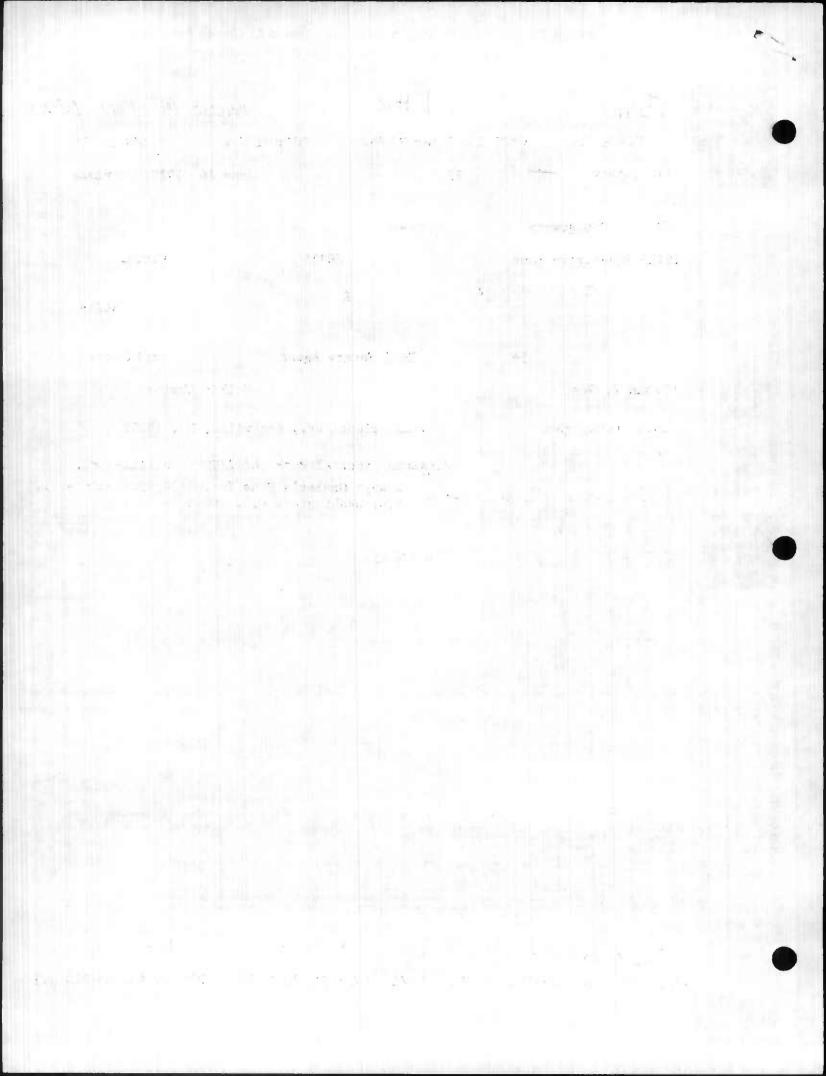
State of Maryland / Department of Health and Mental Hygiene

			Cert	ificate of L	Death		Reg. No.		
4.5.	1. Decedent's Neme (First, Middle, La	est)				2. Deta of De	ath Day	Yeer	3. Tima of Death
Physician /Medical	Helen	Dainow L	evy			Augus			6:15am
Examiner	4e Facility Nema (If not institution, given	e street end number)		4	b. City, Tow	n, or Location of Death	4c. County	of Death	
•	Hebrew Home o			on R	ockvi			tgom	
Funeral Director		Sex 7. Age (In yrs. 1	Yrs.	If Undar 1 Yaar Months Deys	If Under 24 Hours	Min. (Month, Da	h, Year) 12-190	Counti	ace (State or Foreign ny) anada
hend *	10a. State 10b. County	10c. City	y, Town or Loca	ation				10	d. Inside City Limits
death with the Meryland one 23e or 28e-f show Linust be notified at neral Director	MD Montg	omery B	etheso	1 a			10g. Citizen of W	fhat Count	XIXYes 2□No
ifter death with the Mer w terms 23s or 28s-f si inher must be notified Funeral Director	5521 Mohican	Road		2081	6		US	A	
ours after rel', or its Examine I by Fu	11. Menitel Status 1 Never Married 2 Married X Widowed 4 Divorced	12. Wes Decedent Evar in U, Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Detes:	16,	as Decedent of Hi Yes, specify Cuba	spenic Origi n, Mexican, Specify:	n? (Specify Yas or No Puerto Rican, etc.)	Bleci	- Amarica k, White, e White	itc.
72 hc	15. Decedent's E (Specify only highast gr	ducation ada completed)	16e. Decede	nt's Usuel Occupe ind of work done of O NOT use retired	ation luring most o	of working	16b. Kind of Bu	siness/ind	ustry
ed within 72 hours a sysiena. For than "naturel", of the footen for the Completed by	Elementery/Secondery (0-12)	College (1-4or 5+)		onoruse retired acher)		Educa	tion	
d out H	17. Father's Name (First, Middle, Last Aaron Dai	,			18. Mother Pea	s Neme (First, Middle, arl Sou	Maiden Sumem	Θ)	
C/ d m 0	19a. Informent's Neme/Reletionship (Thomas D. Levy					or Aural Route Numbered Bethes			
oemit. Pages 1 end Department of Heelth mportant: If Nem 27 any injury or other tr pace.	20a. Method of Disposition 1 Buriei 2 Cremetion 3 4 Donetlon 5 Other (Special	Removal from State		tion (Neme of etory or other plea Gardens		8/1 ^m /99	20c. Location - Beacot Quebec		
permit. Pages 1 e Department of Het Important: If Item eny Inlury or othe price.	21. Signature of Panerel Service Lice				_	Stein He			
40200	1/ luckad	Lucter	232	2 Carro	11 St	NW Wash	ington	DC	20012 Approximete
Physician /Medical Examiner	23a. Part1. Enter the disease, or comshock, or heert feilure. List only timmediate Ceuse (Finel disease or condition resulting in deeth)					TARCTIO MIA			triterval Batween Onset and Deeth
De la		CARD	AC	DYS	RHY	MIA			
the death certificate be executed by the ettending physician and sched for use as the bunial-trensit hysician/Medical Examiner	Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	r as e consequ						
	that initieted events resulting in death) Last	Due to (or	r es a consaque	ence of):					
death ce e ettendii d for use	Part II. Other significant condittons	contributing to death but not resu	ulting in the unc	tertving cause give	en in Part I	23b. Dld	tobacco use cor	ntribute to	the cause of death?
ras that the death consigned by the ettend for us. I be detached for us. I by Physician/	DEMENTI			, or yang bauto give	J1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10	/		ebly 4 Unknown
been should						24a. Wes	an autopsy rmed?	con	re autopsy findings illable prior to appletion of cause deeth?
The lew spage 2						10	Yes 2 No	1 🗆	Yas 2 No
ysician: The last certificate had director, page	25. Wes case referred to medical		1		26. Plece	of Deeth (Check only o	one)		
	axaminar?	Hospitei: 1 ☐ inpatient 2 ☐	ER/Outpetient	3 DOA Oth	er: 4 Nurs	sing Home 5 Resi	dence 6 Oth	er (Specify)
fer free no	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident Investigation		28b. Time of Injury	28c. tnjun Worl M 1	yat ∢? Yas 2□N	The second section is	how injury occurr	ed	
or Attending s effer death. It Director: After ad in by the fune Certification	3 Suicide 6 Could not to determined		ome, farm, stree	et, factory, office		28f. Location (City or Ton	Street and Numb wn, Stete)	er or Rurai	Route Number,
To the Hospital within 24 hours To the Funeral completaly filled		nystcten: To the best of my knominer: On the bests of examiner and menner stated.							
Me The The	29b. Signature and the sperified	1		29c. License	nu <i>m</i> ber		29d. Date signed	d (Month, L	Day, Year)
~ > F U	► MUG	notinmo)	D29	4942	-	AUG	16	1999
	GNEGORY A	COMPTON	M) (Type, P	6/21/	MON	MOSE !	RO R	6CK	MUE MO
State Registrar	31. Dete filed (Month, Daly, Year) AUG 1 7 19	32. Registrer's Signe	G.	Spork	2				

the state of the s THE PARTY AND LOCAL A CHEST AND ADDRESS OF THE STATE OF administration of the second street

State Registrar 31. Date filed (Month, Day, Year) AUG 16 1999 32. Registrar's Signature

G. Sparks



State of Maryland / Department of Health and Mental Hygiene 99 27224

yland /	Department	OII	nealth and	mental	
	0-46-4-	-6	Donath		

			Ce	ertificate o	of Death		Reg. No.			
Physician /Medical	1. Decedent's Name (First, Middle, Las Sara T. Lo	chboehle	r			2. Dete of D Month Augus		3. Time of Death Year 1999 12:15		
Examiner	4e Facility Neme (If not institution, give Stella Maris H					o, or Location of Dea	ath 4c. County			
Funeral Director	5. Social Security Number 2 1 7 - 38 - 3 0 6 0	7. Age DM 2፟M F	(In yrs. last birthday 93 Yrs.	Months Days Hours Min Month Day Year) - a a c						
2	Usual Residence of Decedent									
ytar	10a. Stete 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
Ma Paris	MD Carro	011		Sykes	ville			1 ☐ Yes 2 ☐ N		
3e or 28e-f a si be noured	10e. Street and Number 1321 Hillcrest	Drive		10f. Zip Cod	1e 7 8 4		10g. Citizen of V	What Country?		
within 72 hours after death with the Manyland sine. Then "retural", or items 23a or 28a-1 ahow the Medical Essention must be notified at empleted by Funeral Director	11. Meritel Stetus 1 Never Married 2 Merried 3 Midowed 4 Divorced	12. Wea Decedent Er Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	12.20	Was Decedent if Yes, specify (Cuban, Mexican, F	o? (Specify Yes or No Puerto Rican, etc.)	Bled	e · American Indien, ck, White, etc. White		
n 72 hours natural, ndeal	15. Decedent's Ed	ucation	16a. Dec	edent's Usuel Oc	cupation		16b. Kind of Bu	usiness/Industry		
ed within 72 ho yglene. wr then "neturn it, me weden!	(Specify only highest grad	College (1-4or 5+	life.	DO NOT use re	one during most o tired) e maker	f working	Dom	estic		
Trade	17. Father's Neme (First, Middle, Last)				18. Mother's	Neme (First, Middle	le, Meiden Suman	10)		
and Mental Hyglene. Lamarked other than summitte avent, the than To Be Comp	Claude Samu				Ма	ry Cath	erine G	illen		
	19e. Informent's Neme/Reletionship (T Mrs. Mary Kilbo	ype, Print) Durne (Da	ughter)	ling Address (St. 1321	reet and Number of Hillcre	or Rural Route Num St Dr. :	ber, City or Town, Sykesvi	Stete, Zip Code) 11e, MD 217		
A D	20e. Method ol Disposition 1 △ Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify		20b. Place of Disp cemetery, cre Dulane	amatani ar athai	n/acal	Dete 8/18/:		City or Town, Stete nium, MD		
permit. Page Department of Important: If any Injury or page.	21. Signeture of Funeral Service Liceni					NERAL H				
de la se	> Brian	Hair	11					(410)79514		
Physician /Medical	23a. Part1. Enter the disease, or comp shock, or heert leiture. List only of Immediate Cause (Final	one cause on each line	he death. Do not er	nter the mode of	dying, such es ca	rdiec or respiretory	errest,	Approximate Interval Between Onset and Deeth		
Examiner	disease or condition resulting in deeth)	a	MONIA	equence of):				Meak		
i i	b .									
e attending physician and of for use as the bunst-transit ician/Medical Examiner										
5 5 6 G	that initiated events	C								
5	resulting in death) Lest		1							
attend I for us								1		
ed by the detache	Pert II. Other algorificant conditions co	ntributing to death but	not resulting in the	underlying cause	given in Pert I.			atribute to the cause of deat		
should should							es an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?		
page 2						10	Yes XX No	1 Yes 2 No		
certificate rector. pa	25. Wes case referred to medical				00 Diversi			10.00		
certific director.	examiner?	Hospitel:			Othor	Deeth (Check only				
2 - H	1 193 28 NO	1 LJ Inpatien			4 Murs	ing Home 5 Res				
r death. sctor: After by the funer iffication:	27. Manner of Death XXNeturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury		njuryat Work? 1 □ Yes 2 □ No		e how injury occur	red		
at Director. After to a by the funeral of in by the funeral Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, lerm, s (Specify)	treet, fectory, off	ice		(Street end Numb own, Stete)	per or Rural Route Number,		
24 hour Funer stely fill	29e. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner stets	xamination and/or is	th occurred et th	e time, date and p ny opinion, deeth	place, and due to the occurred et the time	e cause(s) and ma e, date end plece,	anner as stated. and due to the cause(s)		
within 2 To the comple	29b. Signeture and title ol certifier	4		29c. Lic	ense number		29d. Dete signe	d (Month, Day, Year)		
3 F 8	> Marin 1	melen	lirins		02102	2		7.99		
	30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type		Janou I	alley Ro	d Time	nium, Md 21		
	Marion Kowale	wski, M.	D. Z.	JUU DU.	Laney V	arrey R	1 11110	ma 21		

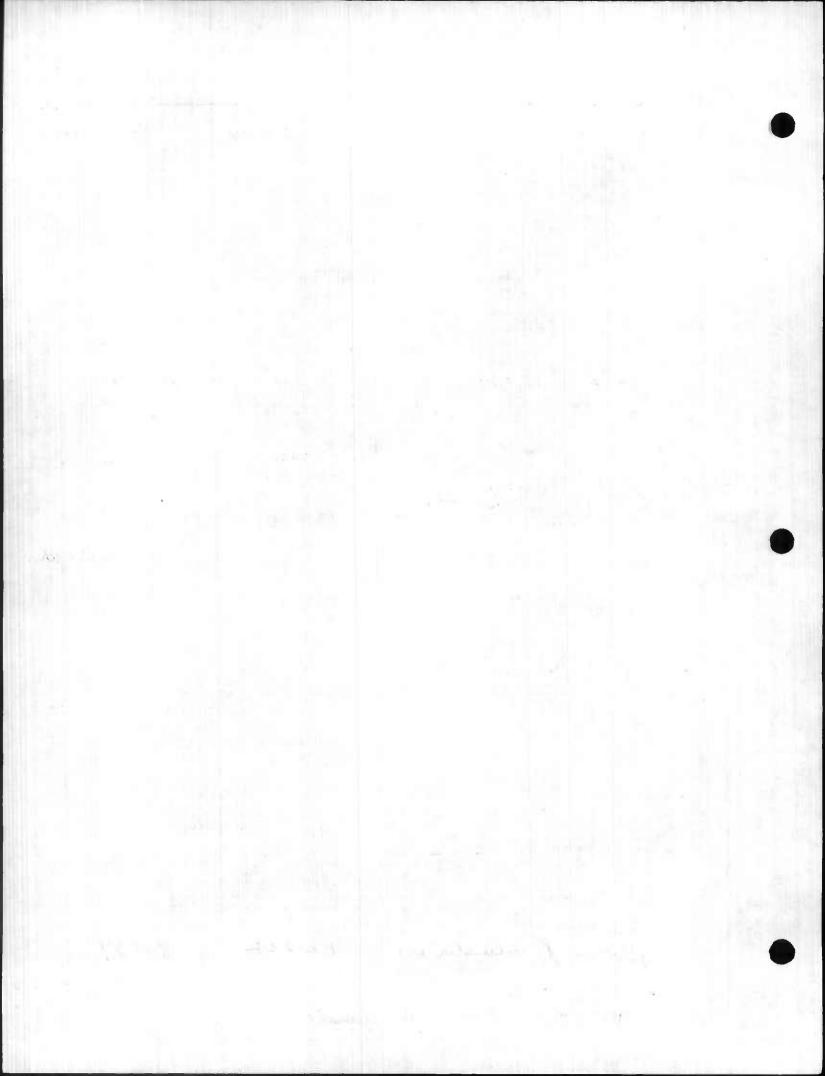
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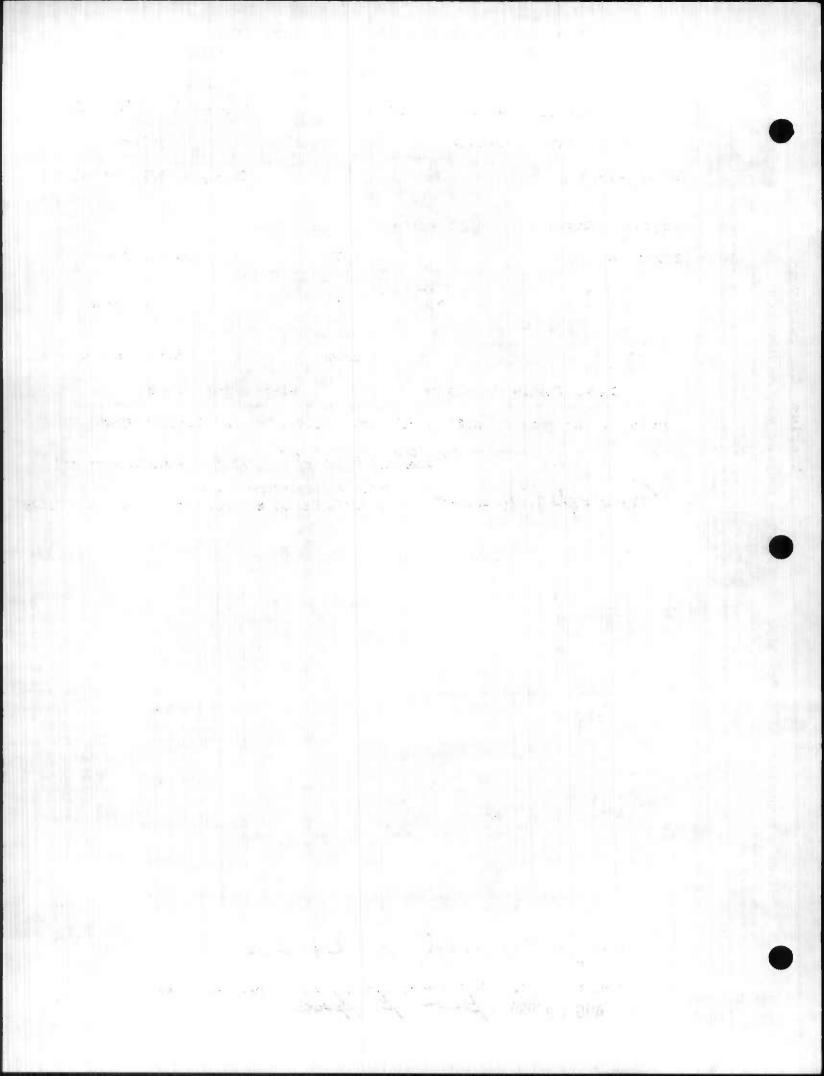
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LOCHBOEHLER,

NAME:



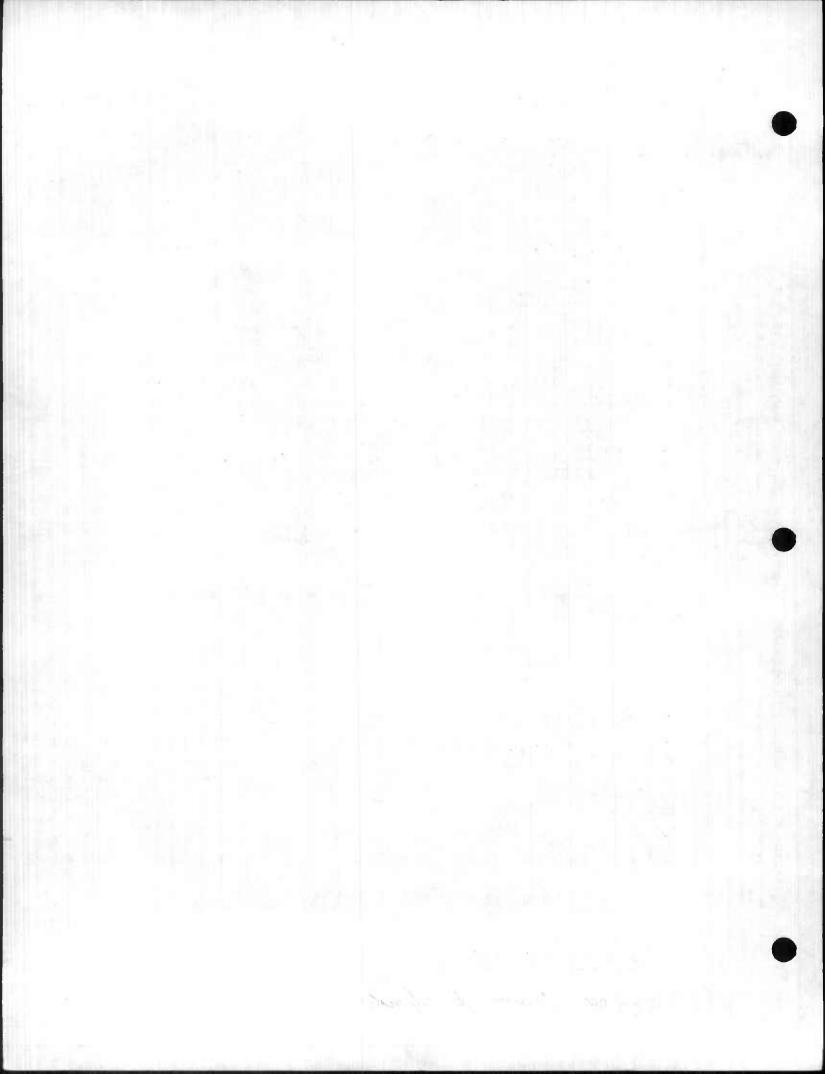
		Decedent's Name (First, Middla, L.	acti		Certificate of		2. Date of Deat	g. No.	3	Time of Death		
Physici				in Lar	rimoro	L	Month	Day	Yaar	900		
/Medi		Charl 4a Facility Name (If not Institution, go			IIMOTE	4b. City, Town, or Loc		4c. County				
		The Memor	ial Hosp	ital		Easton		Tall	oot			
Funeral			Sax 7. / 1□xM 2□ F	Aga (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day,	Year)	9. Birthplace Country)	(Stata or Foraign		
Director		217-28-4529 Usuai Residence of Decedent	TOWN ZOT	72 Y	rs.		January 3	1, 1927	Pennsy	/lvania		
and and		10a. State 10b. County		10c. City, Town	or Location				10d. to	nside City Limits		
ith the Marylar or 28a-f ahow	to	Maryland Carol:	ino	Dento	an .				1	Yes 2 No		
r 28s	rec	10e. Street and Number	riie	Delice	10f. Zip Code		10	g. Citizen of V	What Country?			
h with	a D	225 Siesta Drive			21629		U	nited	States			
er death w frems 23s	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	\$7	13. Was Decedent of I	Hispanic Origin? (Specian, Mexican, Puerto F	city Yas or No-		a - American Ir	ndian,		
0220 ours after death with the Maryla sal, or items 23s or 28s-f show Exercitor reveal be notified at	Y	1 Never Married 2 Married	1 Yes 2 If Yes, Give	□No 1950-	1 ☐ Yes 2 ☑ No			Specifi	<i>/</i> :			
ural.	d by	3 Widowed 4 Divorced	Year or Dates	s: 1952		- * * - * - * - * - * - * - * - * - * -		Cau	casian			
15- n 72 n 72	Completed	15. Decedent's E (Specify only highast g	rada complated)	168. L	Decedent's Usual Occup Giva kind of work dona life. DO NOT usa ratire	during most of working d)	g	IOD. KING OF DE	usiness/maustr	У		
Z1Z	dwo	Elementery/Secondery (0-12)	College (1-4o	or 5+)	Machinist			Chemic	cal Com	pany		
offie office offi-	Bec	17. Father's Name (First, Middla, Las	t)		1.0011211200	18. Mother's Name	(First, Middla, A					
faryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hygiena. Is marked other than "natural", or items 23s or 28s-f show surmatic event, the Medical Exercitor result be northed at	ToE	James Co	ostin La	rrimore		Hilda	Ruth S	inger				
and land		19a. tnformant's Name/Relationship	(Typa, Print)	19b. I	Mailing Address (Straat	t and Number or Rural	Routa Number,	City or Town,	Stata, Zip Coo	de)		
and and a salth n 27 her tr		Esther K. Larrin	more V		25 Siesta D	rive, Dent		***				
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or any highry or other traumatic event, the Medical Examples.		20a. Method of Disposition 1 □XBuriai 2 □ Cramation 3 i	☐Ramovai from Sta	ta Mary lar	Disposition (Nama of crematory or other pla IQ Eastern	Shore	Date	20c. Location -	City or Town,	Stata		
Familian Familian		4 ☐ Donation 5 ☐ Other (Spec	ify)	Veter	cans' Cemet	ery 8/	/23/99	Beulah	, Maryl	Land		
Balt permit. Departm Importa any inju		21. Signatura of Funeral Service Lice	nsee A		Moore Fun	ess of Facility Meral Home,	P.A.					
- 00200		Mandopu	-T. 100	~	12 South	Second Str	ceet. De	nton,	Marylar	nd 21629		
		23a. Part1. Enter the disease or cor shock, or heart failure. List oni	nplications that caus y one cause on each	sed the death. Do no n line.	ot enter the moda of dy	ng, such as cardiac oi	respiratory erre	est,	Inte	proximete ervai Between set and Death		
Physician / /Medical		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.										
Examiner	disease or condition									1 years		
	Je l			Due to (or as a co	risequerica oi).				l l			
58760, icata be executed physician and s the bunal-transit	b. Due to (or as a consequence of):											
e exe	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury thet initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
68760, ificata be exe physician a st the burial-	dica	Cause (Disease or injury that initiated events that initiated events the properties to the properties of the properties										
X 6 as	-		d						i			
Box Bath certif	Physician/M											
P.O.	iysi	Pert tt. Other significant conditions	contributing to death	but not resulting in t	the underlying cause gi	ven in Part I.	23b. Did tobacco use contribute to th					
T that ded b	by Pt	Seps:	5				1 🗆 Ye	2 X No	3 Probably	y 4 ☐ Unknow		
Cords, P.O. Box v requires that the death cert been signed by the attending should be detached for use	D D	1					24a. Was a		24b. Were a	autopsy tindings ble prior to		
aw reconstruction	plet						perion	ned r	comple of deat	etion of cause		
Re lav	Completed						1□ Ye	s 2) No	1 ☐ Ye	s 2 No		
Vital I	BeC	25. Was case referred to medicat				26. Place of Death	(Check only on	B)				
Of V Physici this ce	To	examiner? 1 Yes 2 No	Hospital: 1 (inpe	atient 2 ER/Outp	patient 3 DOA Ot	her: 4 Nursing Hon	na 5 🗆 Reside	nca 6 Oth	ner (Specify)			
DIVISION OF VITAL RECORDS, or Attending Physician: The law requires the after death. Director: After this certificata has been signe in by the funeral director, page 2 should be	:uo	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Dete of It (Month, I		ury Wo	ork?	8d. Describe ho	w injury occur	red			
SIO eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not				Yes 2 No			0	4-111		
or Att	E	4 Homicide determine	286. Pieca of	tnjury - At home, farr etc. <i>(Specify)</i>	n, street, factory, office	2	8f. Location (St City or Town	reet and rvumi , Stata)	per or Hurai Ho	outa Number,		
	edical Certification:	29a, Certifier X Cartifytng P	buetoten: To the ho	et of my knowledge	deeth occurred at the ti	ime, date and piece, a	nd due to the co	uee(e) and m	enner ec cheter	4		
pital ours a seral Dilled	60			of examinetion end/	or investigation, in my							
Hospital 24 hours a Funeral D etaly filled i	쓩	, which makes										
To the Hospital of within 24 hours a To the Funeral Discompletaly filled is	Medic	29b. Signature and title of certifier	Ca									
Division of Vital Records, P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completally filled in by the funeral director, page 2 should be detached for use a	Medic	29b. Signature and title of certifier	6 S)11	ild "	720.01	47232		Sd. Dete signe	18/8/	99		
To the Hospital of within 24 hours a To the Funeral D Completaly filled is	Medic	29b. Signature and title of certifier 30. Name and address of person who	completed cause o	f death (item 23e) (T	7 0			8	18/°	99		
To the Hospital of within 24 hours a To the Funeral D completaly filled	Medio	1 4 M	M.D., 50		Type, Print)	47232		8 21601	18/	99		



State of Maryland / Department of Health and Mental Hygiene

L	ittle	Certifi	icate of De	eath	Red	. No.	2	7225
	Physician /Medical	1. Decedent's Neme (First, Middle, Last) Bonita Virginia Little			Deta of Deeth Month Ugust		Y999	3. Time of Death 07:23 AM.
	Examiner	4a Facility Name (If not institution, give street and number) Easton Memorial Hospital	4b. 0	City, Town, or Location	on of Death	4c. County of	Death	
	Funeral Director	5. Social Security Number 2 1 3 - 9 6 - 6 6 3 7		Under 24 Hrs. 8. C	Dete of Birth Month, Dey, Y		9. Birthple	ece (State or Foreign ry)
	pung Mang	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	on				10	d. Inside City Limits
	and sharp and sharp allied a	MD Caroline	Ridge	1 y				1 Yas 2□No
	shar destri with the Maryland or hams 23s or 24s-f show inhiber must be notified at a Funeral Director	10e. Street and Number Cow Barn RD. Apt. 3	Of. Zip Code 216	60		nited		•
020	S 44 6	1 Never Married 2 Merried 1 Tyes 2 K No	Decedent of Hispa s, specify Cuban, N Yas 2 No S	nic Origin? (Specify lexican, Puerto Rica pecify:	Yas or No- n, etc.)	14. Rece Bleck, Specify:	White, e	
21215-0020	ed within 72 ho tygiens. we then "naturn it, the Medical.] Completed	Elementary/Secondary (U-12) College (1-tor 5+)	s Usual Occupation of work done durin VOT use retired) emaker	n ng most of working	16	b. Kind of Busi		ustry
Maryland	Montal Hy arked other affic event.	James Oscar Little, Sr.		Mothar's Nema (Fir lice Kat				
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	Physician /Medical Examiner	23a. Part1. Enter tha disease, or complications thet caused the deeth. Do not enter the shock, or heert feitura. List only one cause on each lina. Immediate Cause (Finel disease or condition rasulting in deeth) Dua to (or es e consequence)	Ty		mbo	emb	0	Approximata Intervel Between Onsat end Death
68760,	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit leted by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence consequence)		hrow	rbo	sis		
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Records, P.O. Box	The law requires the cate has been signed, page 2 should be d	Depression			24e. Wes en a	d?	com of d	re autopsy findings ilabla prior to apletion of cause eath?
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Division of	To the Hospfall or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	2 Suicido 6 Could not be		2 🗆 No		injury occurre		
DIV	pital or At burs after eral Direc filled in by	4 Homicide datamined 288. Piece of Injury - At nome, ferm, street, the building, etc. (Specify)			City or Town, S	Stata)		Routa Number,
	he Hosp in 24 hou he Funer pletely fill	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigend manner stated.	gation, in my opinio	on, daeth occurred al	tha time, date	end place, ar	nd due to	the ceuse(s)
	To u To u Com	296. Signature and little of certifier A Future M-D	29c. Licanse nu	mber C.M.E.	290	Date signed Augus) 1999
		30. Name and an dress of parson who completed cause of death (Item 23a) (Type, Print 111 Penn Street,		ore, Maryl	and 21	201		

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Robert Harold Miller August 14, 1999 12:44 PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 10104 Phoebe Lane Adelphi Prince George's 8. Data of Birth (Month, Day, Feb. 10, 5. Sociel Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Funeral 1 M 2□ F Months Deys Hours 1919 80 Yrs 707-05-1675 Pennsylvania Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George's Adelphi 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10104 Phoebe Lane 20783 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ρV 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: WWTT Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry United States Department Elementary/Secondery (0-12) College (1-4or 5+) 5+ of Agriculture Botanist 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Samuel Miller Sylvia Hirsch 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Department of Health er Important: if item 27 is eny injury or other trau once. Edythe B. Miller (wife) 10104 Phoebe Lane, Adelphi, Maryland 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 XCremetion 3 ☐ Removel from State 8-16-99 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 21. Signeture of Funeral Service Lights Neme and Address of Fed Rapp Funeral Services, P.A. M00956 933 Gist Avenue, Silver Spring, Maryland 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Anaplastic Astrocytoma, Grade III 6 months Examiner Due to (or es e consequence of) Examin Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Physician/Medical thet initieted events resulting in deeth) Lest Due to (or as e consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings eveileble prior to complation of cause of deeth? Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\text{M}\$ Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, straet, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(e) end manner stated. Medical 29e. Certifier 29b. Signature and title of cegitier 29c. License number 29d. Date signed (Month, Day, Year)

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31. Data filed (Month, Day, AUG 1

Carolyn B. Hendricks, M.D., 5454 Wisconsin Avenue, #1345, Chevy Chase, MD 32. Pegistrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

D37236

August 15, 1999

State Registrar

1-1966

(Carlos) (Charles)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13 Carroll Edgar Morgan 1999 August 5:48 P.M. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Oct. 8 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 12 M 2□ F Months Hours 218-12-5804 74 Director Usual Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show inotified at 1 ☐ Yes 2 No Montgomery Director Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10404 Buckboard Place 20854 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiente. Important; If Item 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examinat page. 1 RYes 2 No WW II If Yes, Give WW II Yeer or Detes: 1 ☐ Never Merried 2 🕅 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Engineer Bell Atlantic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be William A. Morgan Carrie Grimes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Potomac, MD 20854 Loretta H. Morgan - Wife 10404 Buckboard Place 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 8/17/99 Falls Church, Virginia National Crematory 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Joseph Gawler's Sons 5130 WI Ave. N. W. Washington, D. C. 20016 1 homas Lonn 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical 1 Year Glioblastoma Multiforme Examiner Due to (or as a consequence of): Examine physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated surface) Due to (or es e consequence of): Physician/Medicai thet initiated events resulting in death) Last Due to (or es a consequence of): 88 080 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat axaminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28e. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 X Naturel 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 Homicide filled in edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D 37620 August 1999 14, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark A. Godec, M. D. 6001 Muncaster Mill Road Rockville, MD 20855

State Registrar

1999 AUG 16

31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

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Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

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Hospital

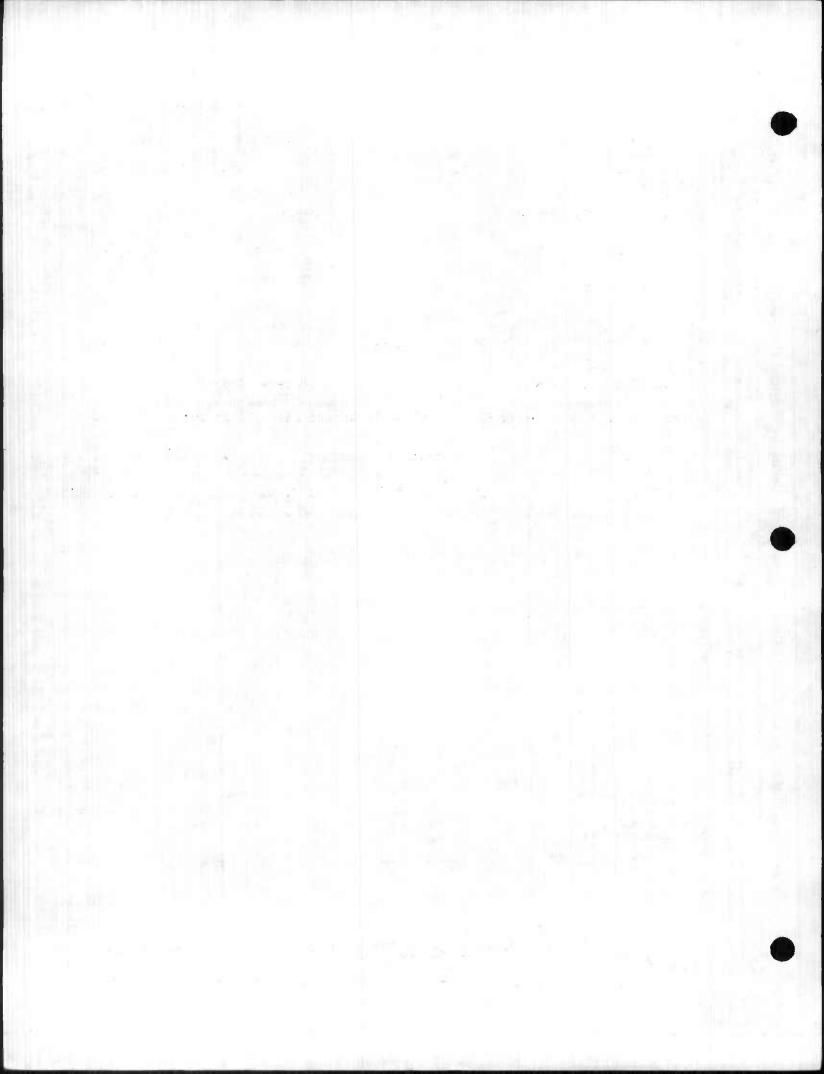
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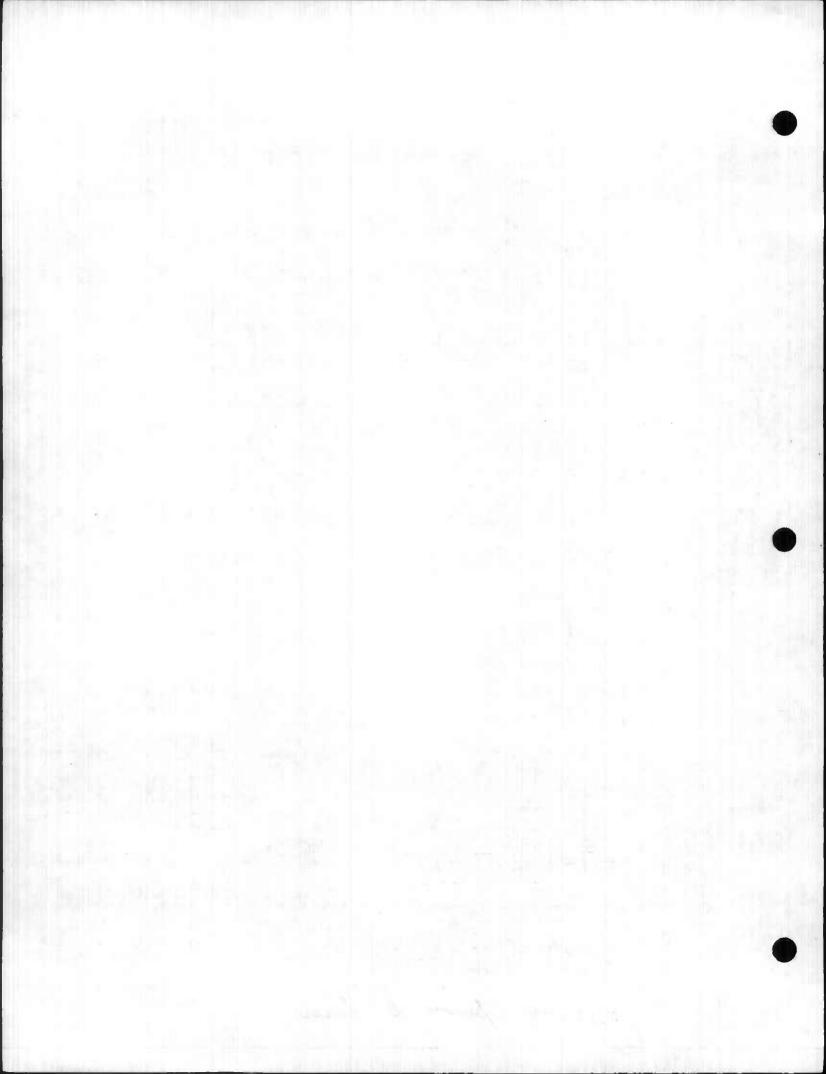
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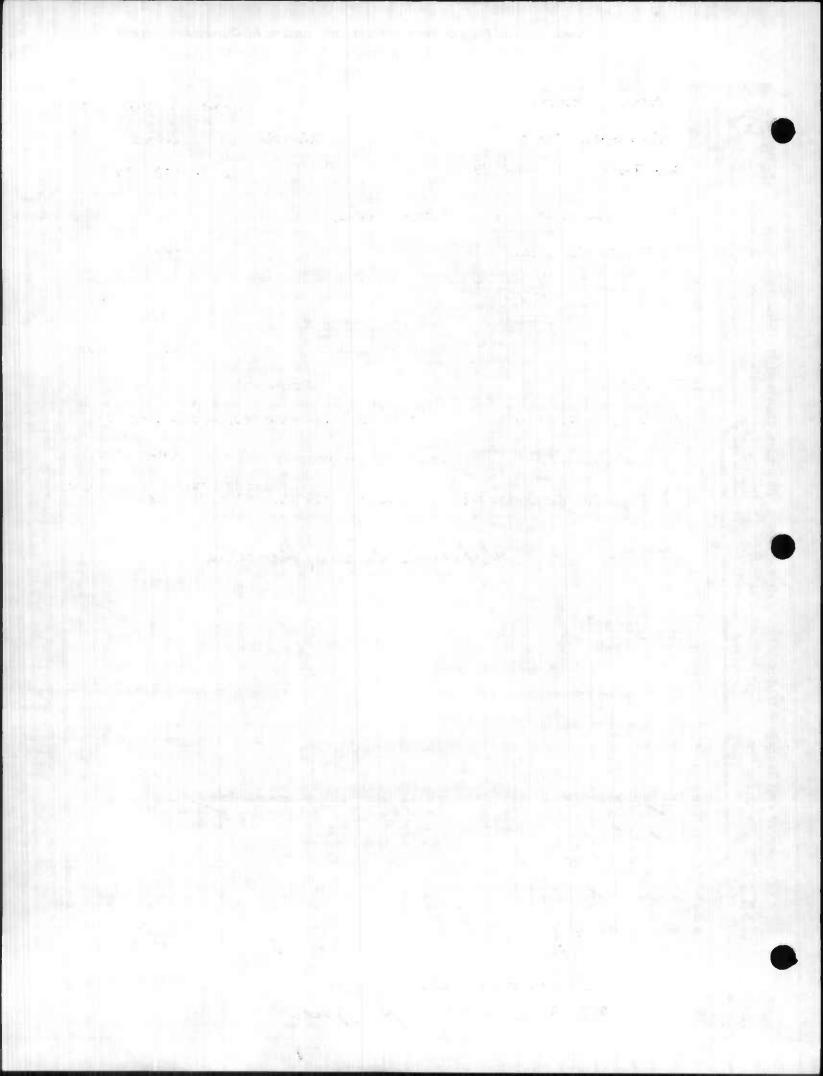
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** 6 24 MM Mettee Aux auretta E /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Haven Hospital dumbia Canty County General 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Yea July 24, (Year) 1923 6. Sex 9. Birthplaca (Stata or Koraign Country) 5. Social Security Number **Funeral** Days Montha 1 M 2 F 76 507-18-9566 Director Kansas Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or items 23a or 28a-f aho The Medical Examiner must be notified at MD Howard 1 Yas 2 No Director Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 River Road 21784 U.S.A. Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, apecify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dales: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: White by 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Photography Photographer 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if feen 27 is marked oth any linjury or other traumatic event page. 89 Luke Elliott Smith LeNore Eva Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mr.s Robyn Metzbower (Daughter) PO Box 1184 Sykesville, MD 21784 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 M Cremation 3 ☐ Removel from State 8/17/99 Hampstead, MD Carroll Cremation Serv. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause or noth line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Hemorrhoye, Left 24 400 disease or condition rasulting in death) Examiner Due to (or as e consequence of) Completed by Physician/Medical Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events rasulting in death) Last Due to (or as a consequence of) physician the burial Box 68760. Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown Mellitis, Hypertension Division of Vital Records. The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Dippatient 1□ Yes 2☐ No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA edical Certification: To After this 28b. Time of 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural A Poers after death.
A 24 hours after death.
A Funeral Director: Aft 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hoep within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of continue D46120 30. Nama and address of person who completed cause of death (item 23a) (Type, Print) Deleon 21044 Little 724 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State AUG 1 8 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

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Paige Haigh intl. Enter the disease, or cook, or heart failure. List on				8/19/99	20c. Location - Ci Staten I	ity or Town, Stete					
nt1. Enter the disease, or cook, or heart failure. List on	21. Signature of Funeral Service Licensee 22. Name end Address of Facility Haight Funeral Home & Chap P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximation of Funeral Home & Chap P.O. Box 195 Sykesville, Md 21784 Approximation of Funeral Home & Chap P.O. Box 195 Sykesville, Md 21784										
ate Cause (Finel or condition g In death)	a. Ala	4	S Disconsequence of):	e/De	mentia		Interval Between Onset and Death				
tially list conditions, sading to immediate Enter Underlying Disease or Injury ated events g in deeth) Lest	b		consequenca of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contrib											
							24b. Were eutopsy findings availeble prior to completion of cause of death?				
					10	Yes 2 No	1 ☐ Yes 2 ☐ No				
case referred to medical				26. Place of	Death (Check only	one)					
Yes 2□ No	Hospital: 1 ☐ Inpat	tient 2 ER/O	utpatient 3 DOA	Other: 4 Nursir	ng Home 5 Resi	denca 8 Other	(Specify)				
Sulcide 6 Could not	tion 28e. Placa of Ir	njury - At home, fa	М	1 Yes 2 No	28f. Location (Street end Number					
rtifier 1 Cartifying I	Physician: To the best	t of my knowledge			lace, end due to the	cause(s) and mann					
neture end title of captuler			29c. Lic	ense number			(Month, Day, Year)				
an Y	case referred to medical investiga for could no determinate of could no determinate only 2 Medical Experience only 2 Medical Experience only 2 Medical Experience on the could no determinate of titler and the could no determinate only 2 Medical Experience only 2 Medical Experience on the could no determinate only 2 Medical Experience on the could not be compared to the could not be compared	case referred to medical line of Death daturel Sulcide Homicide Sulcide Accident Sulcide Getermined Light Cartifying Physician: To the besis and manner services (a) Madical Examinar: On the basis and manner services (b) Lest described (b) Lest described (c) Le	case referred to medical there significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the split in the significant conditions contributing to death but not resulting in the split in the s	Due to (or es a consequenca of): d	Due to (or es a consequenca of): d	ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did 1 24a. Was performed to medical interest of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was performed to medical interest of the significant conditions of the significant cond	Due to (or es a consequenca of): d				



State of Maryland / Department of Health and Mental Hygiene

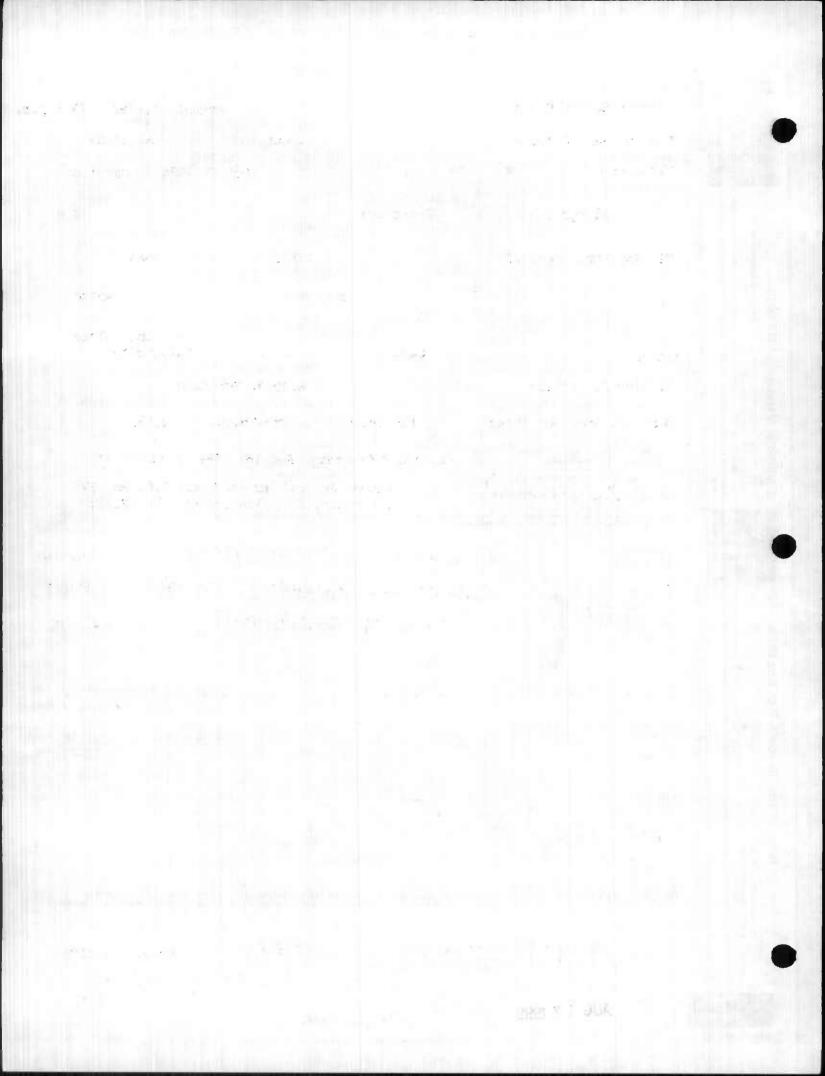
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Am Month Earl Massey Physician 1799 3 AUG /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Carroll Westminster If Under 1 Year Months Days 5. Social Security Number 243-26-4883 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 4 1926 Birthplace (State or Foreign Country)
 NC Funeral Months 10XM 2DF Hours Director Usual Residence of Decedent 10c. City, Town or Location Sykesville permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiens. Irreportant: If Item 27 is marked other than "natural", or items 23s or 28s-f show with highery or other traumatic event, the Medical Examples must be notified at police. 10a. State 10h Counts 10d. Inside City Limits Md Carroll 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7309 Second Avenue 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: black ğ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) janitor maintenance 18. Mother's Name (First, Middle, Maiden Surname)
Meta Elliot 17, Father's Name (First, Middle, Last) Sidney Massey 80 19a. Informant's Name/Relationship (Type, Print)
Gail Jones (social worker) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Stoner Ave. Westminster, Md 21157 20b. Place of Disposition (Name of cometery, crematory or other place)
Mt. View Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8-13-99 Marriottsville Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis day Examiner Due to (or as a consequence of): Examine physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Hospital: 1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of Injury (Month, Day Year) e Hospital or Attending Ph n 24 hours effer deeth. e Funeral Director: After th 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 (Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) august, m.p. D 52479 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA K-M MD at carroll county General Hospital at 200 memoria | Avenue Westminster, MO 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 1999 Registrar

State of Maryland / Department of Health and Mental Hygiene

				Otato of I	viai y iai i	Cer	tificate	e of	Death		Reg. No.	9 5	77232		
		1. Decedent's Na	me (First, Middle, L	ast)						2. Date of De	ath	Maria	3. Time of Death		
	Physician /Medical	Shirley	Helena	Mason						Month	Day ist 12.1	Year 999	2327 p.m.		
1	Examiner	4a Facility Name	(If not institution, g	ive street end numb	er)				4b. City, Town, or				- PEM		
		Sacred	Heart Ho	spital					Cumberl	and	Al	legar	ny		
	Funeral Director	5. Social Security 271-34-	-5019	Sex 7. 1 □ M 2 √ F	Age (In yrs. i	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		h y, _{Year)} 1934		place (State or Foreign ntry) yland		
_	pu *	Usual Residence	of Decedent 10b. County		10c City	y. Town or Loc	eation					T	10d. Inside City Limits		
	aho and	MD	Allegan	V		Frostb							1⊠ Yes 2□ No		
	ifier death with the Mei r Itams 23a or 28s-f si inter must be northed Funeral Director	10e. Street and N		•			10f. Zip	Code			10g. Citizen of \	What Cou	ntry?		
	with Did								01500						
	ne 2%	11. Meritel Stetus	aw St., A	12. Was Decede	nt Ever in U,	S. 13. W	Vas Deced	lent of I	21532 dispenic Origin? (S an, Mexican, Puer	Specify Yes or No		USA 14. Race - American Indien,			
21215-0020	by by	1 ☐ Never Ma	rried 2 Married	Armed Force 1 Tes 2 If Yes, Give Year or Date	X No				an, Mexican, Puer Specify:	to Rican, etc.)	Specify	ck, White, v: Wh	nite		
2-0	ygiene. Ner then "neture It, the Wedical	/0-	15. Decedent's I			16a. Deced	ent's Usue	I Occup	petion during most of wa	ndrina	16b. Kind of B	usiness/In	dustry		
21	thin 7	Elementary/Sec	ecify only highest g condary (0-12)	College (1-4	or 5+)	lite. D	O NOT us	e retire	d)		Frostbu	rg St	cate		
	filed within Hygiene. other than ent, tre M	10 th				Cook					Univers	-			
Maryland	be file d oth even		e (First, Middle, Las							me (First, Middle,		ne)			
y a	2 should be fined and Mentel It is marked of summit even		n B. Garl							. McKenz					
Mar	2 0 5 5		Name/Relationship						and Number or R				> Code)		
	1 end 2 Health em 27 I	20e. Method of Di	Geary/	daugnter	20h P	194 (lace of Dispos			t., Fros	Date Date	D 2153		own State		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, tra Medical DREs. To Be Completed	1 ₩ Burial	2 ☐ Cremation 3	Removal from Sta	ce)										
Itim	rtant riant	4 Donation 5 Other (Specify) St. Ann's Cemetery, Aug 16, 1999 Avilton, MD 21. Signature of Fune a Service Licenses Newman Funeral Homes, P.A., P.O. Box 275													
Ba	permit. Pages 1 end Department of Health Important: If Item 27 any Injury or other tr pncs.	> au	1//			N	ewman	ı Fu				Box 2153			
	Physician	23a. Part1. Enter shock, or he	une di eese, or con and a ure. List onl	mplicetions thet cau y one ceuse on eac	h line.	n. Do not ente	or the mode	e ot dyi	ng, such es cardia	c or respiratory a	rrest,		Approximete Interval Between Onset and Death		
1	/Medical Examiner	Immediate Cause disease or condit resulting in deeth	ion	a. /	140C	AM)	H	. 1	HFAR	CTION)	1	20 min		
	je line				7 000	r as a consequence	uence or):		LIERY		ASE	1	8 4rs		
	outed ansit	Sequentially list of	conditions	b	~ Due to (or	r as a consequ	uence of):	M	401-1	10130	76.100		0 4/3		
o,	an en iriel-tr	if eny, leading to cause. Enter Uni	immediate derlying		Din	155		n	(EU)	TILL			PUR		
68760,	death certificete be executed etending physician end set for use es the buniel-transit strian/Medical Examir	Sequentially list conditions, if env, leading to immediate cause. Enter Underlying Cause (Disease or injury that mitilated events resulting in death) Last b. CORONOMY ANTRY DIS													
	25 010	Toodking in doubt	/ 2031												
Box	ith ce trendi			d											
0	ires thet the death cert signed by the ettending Id be detached for use Id by Physician/M	Part II. Other sign	ificant conditions	contributing to deat	n but not resu	ulting in the un	derlying ca	ing cause given in Pert I. 23			tobacco use co	ntributs t	to the cause of death?		
0	thet the ed by detac									1 🗆	Yes 2□ No	3 Pro	bably 4 Unknown		
ds,	signed d be d									24a Was	an autopsy	24b. W	Vere autopsy findings		
Record	non non									perfo	rmed?	CC	Vere autopsy findings vailable prior to ompletion of cause		
360	The law ete hes b page 2 sl												f death?		
a	: The licete he r, page										Yes 2 No	1	☐ Yes 2☐ No		
Vital	Physician: The this certificate ral director, page TO Be Co	25. Was case reference?		Hospitai:		-		Ot	hor	ath (Check only			4.1		
of	Physic this corral dire	1 Yes 28	□ No ath	1 ☐ Inp		ER/Outpetient 28b. Time of		/A	4 LI Nursing	Home 5 Resi	how injury occur		ry)		
On	ding h. After fune	1 DNatural 2 ☐ Accident	5 Pending investigati	(Month,	Dey Year)	Injury	М	8c. Inju Wo	rk?]Yes 2□No						
Division	tal or Attending P rs effer death. al Director: Affert led in by the funers Certification:	3 Suicide	6 ☐ Could not	be 28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, fectory	, office		28f. Location (City or To	Street and Number, State)	ber or Rur	ral Route Number,		
	To the Hospital or Attending Phwithin 24 hours eliter death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one)	A Certifying F 2 ■ Madicat Exa	Physician: To the be aminar: On the basis and manner	s of examinat	wledge, death tion and/or inv	occurred estigation,	et the ti	me, date and piac opinion, deeth occ	e, and due to the urred at the time,	cause(s) and m date and piaca,	anner as : and due !	stated. lo the cause(s)		
	of the omple	29b. Signature an	nd title of certifier)		290	. Licen	se number	39 1	29d. Dete signe	ed (Month,	, Day, Year)		
	- s + 0		Clus	eller 4	COPLES	1120		F	13166			12	1000		
	,1	30. Name and add	dress of person who	o completed cause of	of death (Item	23a) (Type 1	Print)				August		1999		
	4	4	& Broi	DOWAT	TAI	2N 10	RVO	ice	tro.	s pg use	lust	7			
	State	31. Date filed (Mo	AUG 1 7	1999 32. Heg	istrar's Signa	, A		1				1	132		

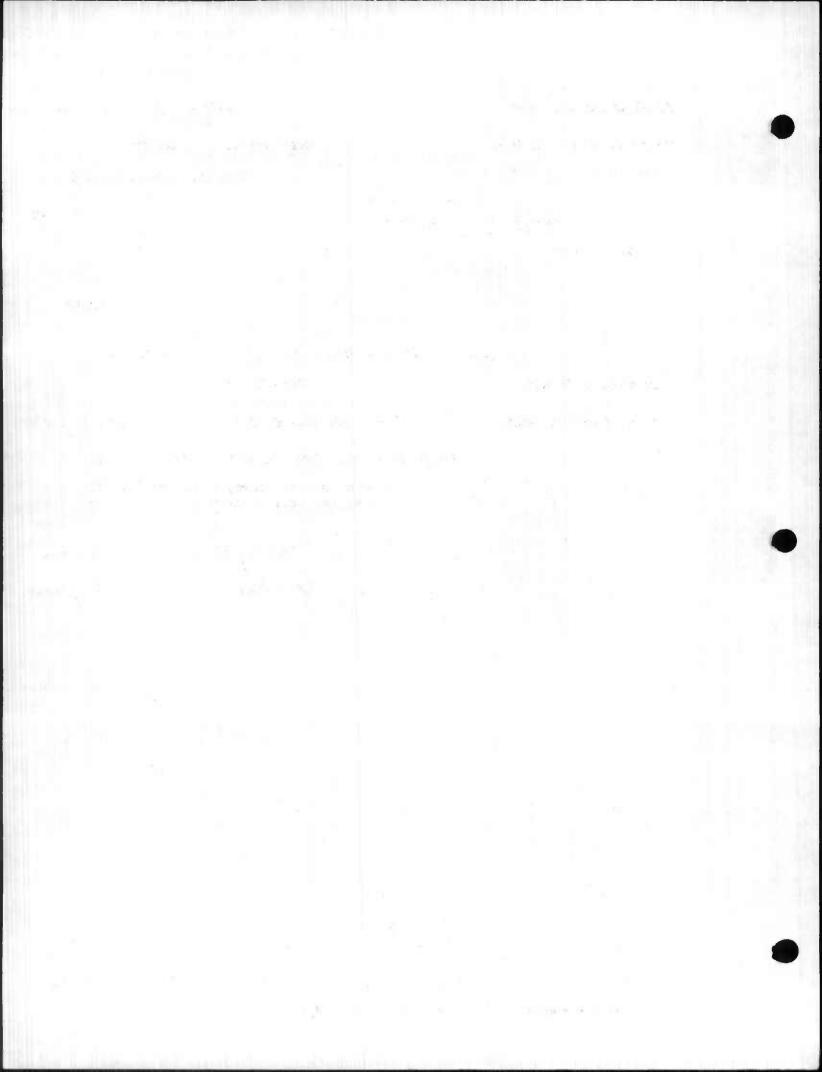
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State of Maryland / Department of Health and Mental Hygiene

_			Certificate of				neg. tro.				233	
ı	Physic	an	1. Decedant's Name (First, Middle, Last)					2. Date of Death	Day	Year	3. Time of Deeth	
J	/Medi		Ethel Catharine Maust					AUG	12	1999	3:45pm	
9	Examir	ner	4a. Fecility Neme (If not institution, give street end number)				4b. City, Town, or Location of Death 4c. County of Death					
		Director	Goodwill Mennonite Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und			er 1 Year	Grantsville Garrett					
s.	Funeral Director		5. Social Security Number 176-14-6148 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.			s Deys						
Baltimore, Maryland 21215-0020	the Maryland 28a-f show out ad at		10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 □ Yes				
			PA Somerset 10e. Street and Number	orings	ip Code							
	23a or	ral Dir	72.			15562			og. Citizan of V U	USA		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at	To Be Completed by Funeral I	1. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yas, Give Year or Dates:			ispanic Origin? (Specify Yes or No- n, Mexicen, Puerto Rican, etc.) Specify:		14. Race - American Indian Black, White, etc. Specify: White		etc.		
			15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 2 years		16a. Dacedent's Us	ent's Usual Occupation		16b. Kind		d of Business/Industry		
					life. DO NOT use reti		one during most of working of other of the o					
	DD								Educa			
	m = 0 =		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	faiden Sumerr	e)		
			Christian A. Beachy				Mary Ann Keim					
	d 2 should th and Mer 7 Is marks traumatic						et end Number or Rurel Route Number, City or Town, Stete, Zip Code)					
			Jean M. Durst/daughter		175 Hetr	ick	Rd., PO B	ox 28, G	rantsv	ille,	MD 21536	
	gas 1 and of Haalt if itam 2		20a. Method of Disposition 1 Burlal 2 □ Cremation 3 □ Removel from Sta	0.00	ce of Disposition (Natery, cremetory or	eme of other ple	се)	Date 2	Oc. Location -	City or To	wn, State	
	Pag ment: I		4 Donation 5 Other (Spacify)		le Glen C	em.				11, 1	PA	
	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other Once.		21. Signeture of Funival Service Licensee 22. Name and Address of Facility Neuman Funeral Homes, P.A., PO Boy 275									
			23a. Part1. Enter the disease, or pemplications that ceus	sad tha death.	Do not antar tha mo	lille	r St., Gr.	antsvill or respiratory arra	e, MD	2153	Approximata Interval Between	
d	Physician		23a. Part1. Enter the disease, or complications that ceusad the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, Approximate Interval Between Onset and Death									
2	/Medical	edical Examiner	Immediate Cause (Final disease or condition a. FATAL Ventricular Arrhothmia 5 min.							5 mia		
П	ceta be executed physician and street bunel-transit		Immediate Cause (Final disease or condition resulting in death) a. TATAL Vinticular Arrhythmia 5 min. Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):									
			_ Core	mpra	Acto	· ~	1)3500			5	5 years	
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50,	e exe		Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events					1				
68760,	± 00 €	dica	that initiated events rasulting in death) Last Due to (or as a consequence of):									
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0	tha day		Part II. Other significant conditions contributing to death	but not resulti	ing In the underlying	ceusa giv	a givan in Part I. 23b.		Did tobacco use contribute to the cause of death?			
Division of Vital Records, P.(s that th yned by e datec		demin tia				24a. Was		Yes 2 No 3 Probebly 4 Unknown			
	 raquires that the deeth car been signed by the ettendin should be deteched for use 										allable prior to mpletion of ceuse	
	Tha law eta has t page 2 s							of death				
	Attanding Physician: ir daath. ector: Aftar this cartific by the funaral director.		25. Was cesa raferred to medical				00 Pl (D m)	1 □ Ya		1	Yes 2 No	
		Medical Certification: To Be										
			27. Manne of Death 1 Patural 5 Pending 2 Accident Investigation	28c. Injui Wor								
			3 Suicide 4 Homicide City or Town, Stete) 288. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify)							l Route Number,		
	To the Hospital or within 24 hours after To the Funeral Dirticomplately filled in		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s)									
	thin the		one) and memmer statad.									
	5 5 5 5 E		29b. Signature end little of certifier							ned (Month, Day, Year)		
			1-06	/	an	N	34079		Hug	12	1999	
	2		30. Nama and address of person who completed cause of	t death (Itam 2	(Type, Print)	(Frants	1110	mo	2	1536	
	Sta	te	31. Date filed (Month, Dey, Year) 32. Regi	strer's Signatur		,			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Registr	25	A116 1 7 1000 M	and a	All A							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Madeline Blanch Masters 14, 1999 Aug. 12:30 a.m. 4a Facility Name (If not Institution, give straat and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 659 Boy Scout Road Oakland Garrett If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) Months Days Houra Min. 1□ M 2☑ F Yrs. July 6, 1924 West Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Garrett 0akland 10f. Zip Code 10g. Citizen of What Country? 659 Boy Scout Road 21550 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Bleck, White, etc. 1 □ Never Married 2 □ Merried 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Buainess/Industry 15. Decedent'a Education (Spacify only highast grada complated) Elementery/Secondary (0-12) Coilege (1-4or 5+) Housewife Home 18 Mother's Name (First Middle Maiden Sumema) 17. Father'a Name (First, Middla, Last) James Samuel Messenger Pamela Jane Long 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 414 S. 8th Street, Oakland, Md. 21550 James C. Masters/Son 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 8/16/99 4 ☐ Donetion 5 ☐ Other (Specify) Friend Cemetery Oakland, Maryland 22. Nama and Address of Fecility 21. Signature of Funerel Service Licensee Stewart Funeral Home 23a. Pert1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic liver carcinoma vears Due to (or as a consequence of): uterine carcinoma vears Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown chronic obstructive pulmonary disease 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy diabetes mellitus

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

7 is marked other than "naturel", or items traumatic event, the Mancel Examples in

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: if flem 27 is merked other than "naturel", or flen eny Injury or other traumatic avant.

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

the Marylend

death

5. Social Security Number

10e. Street and Number

12th

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

1 Yea 2 No

Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

diseese or condition resulting in death)

10a State

MD

235-40-0282

Usual Residence of Decedent

siclan and buriel-transit physiclan the SS 9SD 0 the signed by the hes page 2 certificate

certificate be executed or Attending Physician: After this funeral 24 hours after death.

Funeral Director: A filled in by Hospital completely To the I

Division of Vital Records, P.O. Box 68760.

Physician/Medical à Completed Be 9

Examiner Certification:

25. Was case referred to medical examiner? 27. Manner of Death

edicai

(Check only one) 29b. Signature and title offertifier

5 Pending

investigation

6 Could not be

29c. License number

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

2 LINO

1 ☐ Yes 2 ☐ No

1 Yes

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only ona)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

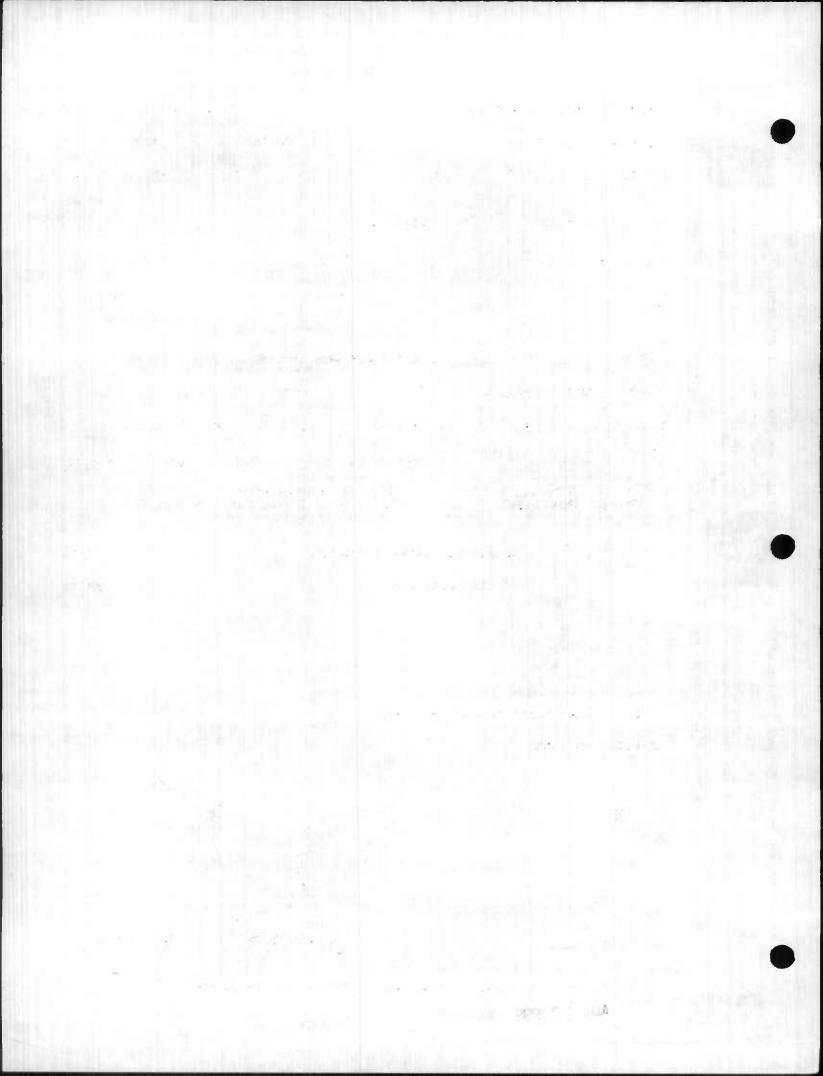
Hospital:

28a. Date of Injury (Month, Day Year)

Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550 31. Date filed (Month

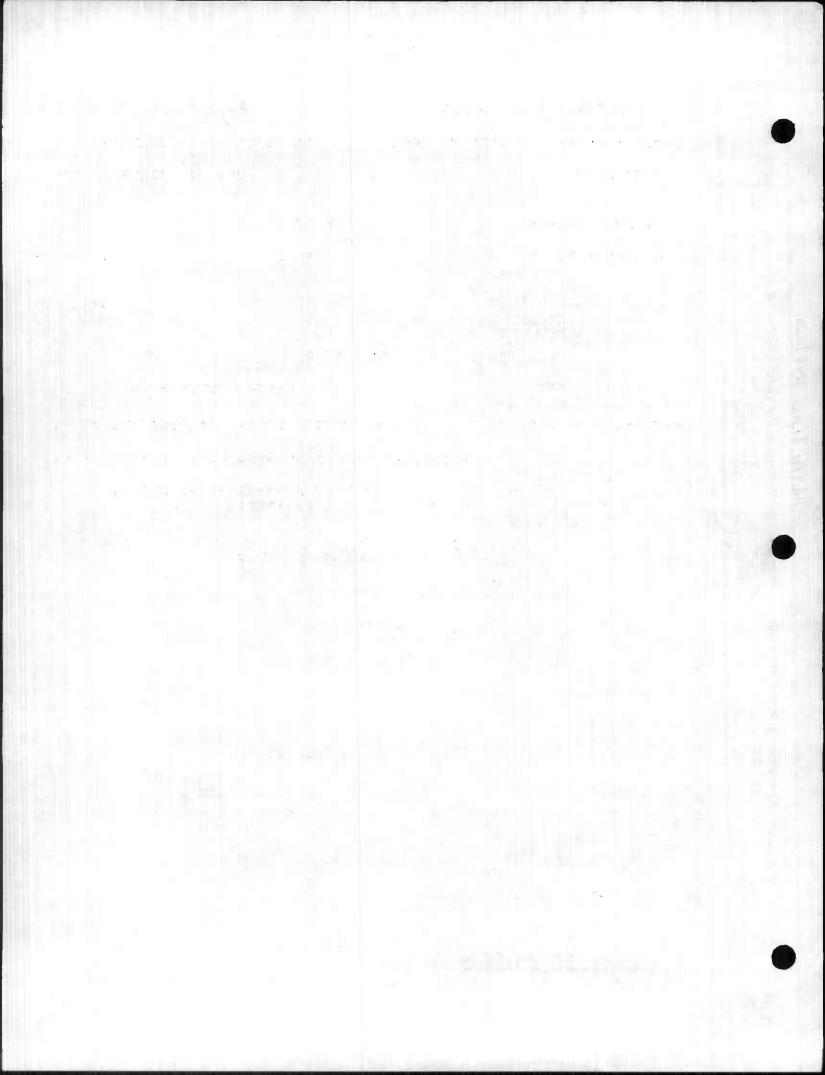
State Registrar

32. Registrar's Signature

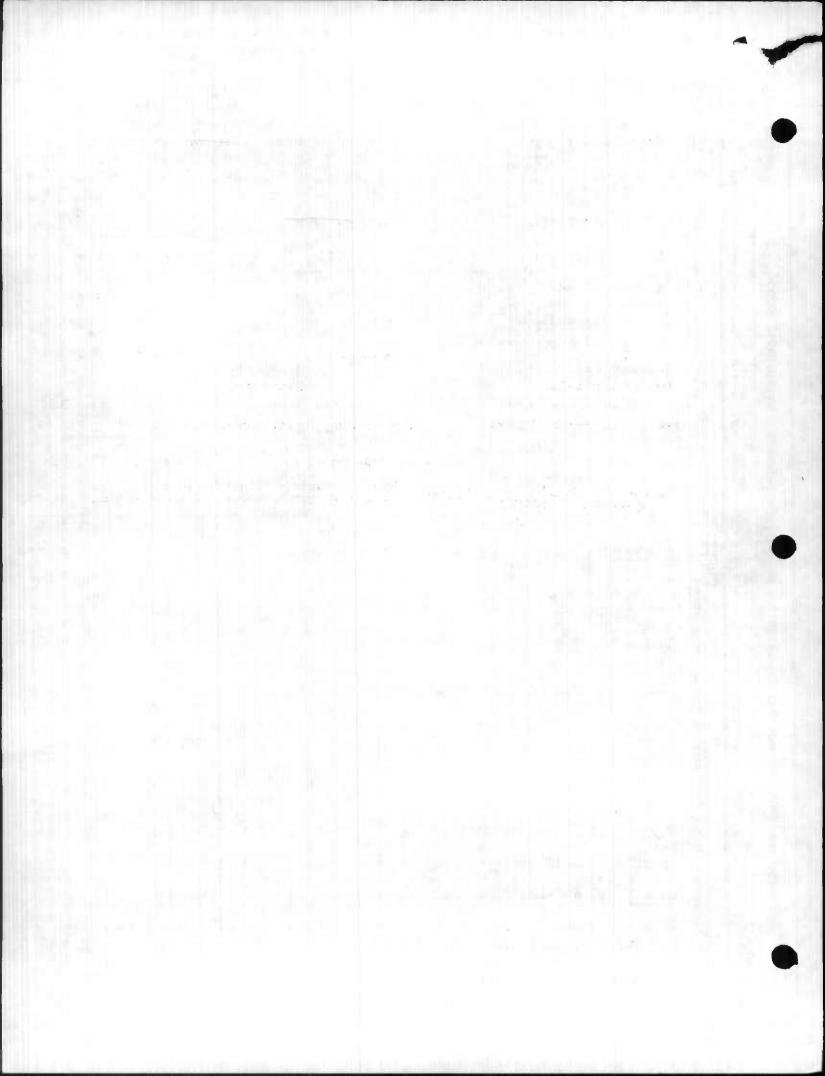


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of		Reg. No.
Physician	Decedent's Neme (First, Middle, Last)		2. Dete of D	. Dev Year
/Medical	MADELETNE LAZADO NOTAN		Augus	10 100 7155 0
Examiner	An English bloom a Managarate sales about a same and a surface bank		4b. City, Town, or Location of Dee	th 4c. County of Deeth
4	GENESIS ELDERCARE NURSING	HOME	LA PLATA	CHARLES
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. les	Months Devs	Hours Min. 8. Dete of B	irth 9. Birthplace (State or Foreign Country)
Director	549-20-6070 1 ^{1 M} 2 F 91	Yrs.	JULY 2	22,1908WASHINGTON,DO
P 2	Usual Residence of Decedent 10a. Stete 10b. County 10c. City,	Town or Location		10d. insida City Limits
enyla a thou	CANONICAL CONTRACTOR C	TOWIT OF ECCATION		1 Yes 2 No
with the Meryland a or 28a-f show De notified at	MARYLAND CHARLES		A PLATA	X
Olra	10e. Street end Number	10f. Zip Code		10g. Citizen of Whet Country?
ath w	1 MAGNOLIA DRIVE		20646	U.S.A.
d 21215-0020 d 21215-0020 filed within 72 hours effer death with the Meryland Hygiene. ther than "natural", or itema 23a or 28a-f ahow brit, the Medical Examinat must be notified at a Completed by Funeral Director	11. Mentel Stetus 12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of I if Yes, specify Cub	Hispenic Origin? (Specify Yes or N en, Mexican, Puerto Rican, etc.)	Io- 14. Reca - American Indian, Bleck, White, etc.
020 urs efte transfer		1□ Yes 2□No	Specify:	Specify:
15-00°		10. Desertable Have Occur		WHITE
21215-0 ed within 72 ho vgiene. naturi rt, the Medical	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. Kind of Business/Industry
9 / a 212- 212- 1 withir inner- than	Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS			OHN HOME
d 212 filed within them out, the training of training of the training of the training of train		HOMEMAK	18. Mother's Name (First, Middle	OWN HOME
and dbe fill mital H			MARIE VonU	
lore, Maryland 21215-0020 ges 1 and 2 should be lifed within 72 hours eft to f Heelth and Mental Hygiene. It from 27 is marked other than "natural", or or other traumatic event, the Wedical Example To Be Completed by F	19a. Informent's Neme/Reletionship (Type, Print)	19h Mailing Address (Street		ber, City or Town, State, Zip Code)
Mar Mar d 2 sho th end 7 is m				
other tr	20a Method of Disposition 20b. Ple	4021 BLACKB be of Disposition (Neme of	Dete	LDORF, MD. 20603
Hadeline Baltimore, Mary Department of Heelth, end A mortant: If hem 27 is ma my injury or other trauma	1 Buriel 2 Cremation 3 Removal from State	netery, cremetory or other pla	ce)	
Hade Baltimo permit. Peges Department of Important: It is any injury or tonce.				9 ALEXANDRIA, VA.
Bal Bal	21. Signeture of Fuperel Servica Licensee	22. Name end Addre	D FUNERAL SER	VICE P. A.
5 - 40310	Muhael O. June	TA PLA	TA . MARYT.AND 2	0646
1998	23e. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dyi	ng, such es cardiac or respiretory	errest, Approximate Interval Between
Physician	1	1		Onset and Deeth
/Medical Examiner	Immediate Ceuse (Fine) disease or condition	Chebral Nasc	ular accident	
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Boute tran	Sequentially list conditions,	s a consequence of):		
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U = -= U		beter mell	the	
Box Beth cert ettendin for use				
D. O e de	Pert II. Other significant conditions contributing to death but not result	ing In the underlying cause gi	ven In Pert I. 23b. Di	d tobacco use contributa to the cause of death?
Division of Vital Records, P.O. Box (or Attending Physician: The law requires that the deeth certificate death. Director: After this certificate has been signed by the eltending of the funeral director, page 2 should be deteched for use ertification: To Be Completed by Physician/Me			10	Yee 2 No 3 Probably 4 Unknown
S S S S S S S S S S S S S S S S S S S				
The law requirate has been a page 2 should			24a. We	24b. Were autopsy findings avellable prior to
ec.				completion of cause of death?
E de			10	Yes 2 No 1 Yes 2 No
/ita	25. Was case referred to medical		26. Piece of Deeth (Check only	(one)
Nysical hysical direction of To E	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 El	R/Outpetient 3 DOA	her: 4 Nursing Home 5 Re	sidenca 6 ☐Other (Specify)
o P P O		8b. Time of 28c. Inju	ry at 28d. Describ	e how injury occurred
ior ndin ath. r: Aft se fur	1 ☐Naturel 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		Yes 2□No	
Vis Ansards by #	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At hom building, etc. (Specify)	e, ferm, street, fectory, office	28f. Location	(Street end Number or Rural Route Number, own, State)
Division of the or Attending P is a first death. al Director: After the funers ded in by the funers Certification:	building, etc. (Specify)		City of .	owi, 51616)
Applit hour mera				
ne Hospi n 24 hou Petely file	(Check only one) 2 Medical Examiner: On the basis of examination end menner steled.	n and/or investigation, in my o	opinion, death occurred at the time	e, dete and pisca, end due to the cause(s)
Division of Vital Rector the Hospital or Attending Physician: The law within 24 hours effor death. To the Funeral Director: Affor this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compi	29b. Signeture end title of certifier	29c. Licens	se number	29d. Dete signed (Month, Dey, Year)
	1) IATUL	1)2:	2574	8/19/99
	30. Name and address of person who completed cause of deeth (Item 2	3e) (Type, Print)	/	
	Timothy R. Pace 12070	Old Line	Center u	aldorf, md.
State	31. Dete filed (Month, Day, Year) 32. Registrer's Signetu	TO 1. 1	4	,
Registrar	AUG 2 0 1999	D. Spork	2	



Alek Thomas Nelson August 1, 1999 8:00P 8226 Sallery Court 8226 Sallery Court 10 Source of Department of Control Court 10 Source of Department of Court of Death Montagomery 10 Source of Department of Court of Death Montagomery 10 Source of Department of Department of Court of Death Montagomery 10 Source of Department of Departm		,8/17/99				Ce	ertifica	ite of	Death		Reg. No.		
46. City. Town, or Localitys (Gastlery Court Steam of Court Mont gomery Williams (Same Steam of Court Steam o	n	. Decedent's Name) (First, Middle, i		as Ne	lson				Month	Day		3. Time of Death 8:00PM
100. Steeler and Number 100. City, Town or Location Village Montgomery Village Montgomery Village Montgomery Montgomery Village Montgomery Village 100. End of the State 100. Steeler and Number 82.29 Gallery Court 10. Steeler and Number 10. West Deceder Civil 10. Steeler and Number 10. Steeler and Number 10. Steeler 10. Ste	5.	8229 Ga Social Security N 245-69-10	allery 0	Court Sex 7.	Age (In yrs.			M ler 1 Year	ontgomen if Under 24 Hr	s. 8. Date of Bi (Month, D	ge Mo	ntgomen	place (State or Fore
Maryl and Mont gomery Mo	-				10c Ci	tv. Town or l	ocation						10d. Inside City Lim
Separation Sep	,	Maryland		merv				Vill	age				1 X Yes 2 □ I
12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Hispanic Origin? (Specify Yes or Notice 12. Was Decident of Working (First, Middle, Malden Surmans) 15. Decedent Specify 12. Was Decident of Working (First, Middle, Malden Surmans) 16. Elementary School 17. Father's Name (First, Middle, Malden Surmans) 17. Father's Name (First, Middle, Malden Surmans) 18. Informatic Name/Fielationship (First, Print) 18. Malaing Address (Street and Number of Plans Floute Number. City or Town, Stelle, Zip Code) 20. Was Informatic Name/Fielationship (First, Middle, Malden Surmans) 18. Malaing Address (Street and Number of Plans Floute Number. City or Town, Stelle, Zip Code) 20. Was Informatic Name/Fielationship (First, Middle, Malden Surmans) 18. Malaing Address (Street and Number of Plans Floute Number. City or Town, Stelle, Zip Code) 20. Was Informatic Name/Fielationship (First, Middle, Malden Surmans) 18. Malaing Address (Street and Number of Plans Floute Number. City or Town, Stelle, Zip Code) 20. Was Informatic Name/Fielationship (First, Middle, Malden Surmans) 18. Malaing Address (Street and Number of Plans Floute Number. City or Town, Stelle, Zip Code) 20. Was Informatic Name/Fielationship (First, Middle, Malden Surmans) 18. Malaing Address (Street and Number of Plans Floute Number. City or Town, Stelle, Zip Code) 20. Code and Number of Record Number of Plans Floute Number. City or Town, Stelle, Zip Code 20. Code and Number of Record Number of Plans Floute Number. City or Town, Stelle, Zip Code 20. Malaine Number of Flour Number of Plans Floute Number of Plans Floure Number of Plans Floure Number of P						Tonego			Lage		10g. Citizer	n of What Cou	ntry?
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David John Nelson 19a. Informent's NemerRelationship (Type, Print) Brandon G. Nelson/Mother 8229 Gallery Court, Montgomery Village, Maryla 20b. Meals of Deposition 1 Relative of English (Specify) 1 Revisit 2 Comments of South (Specify) 2 Revisit 3 Comments of South (Specify) 2 Revisit 3 Comments of South (Specify) 2 Revisit 3 Comments of South (Specify) 2 Revisit 4 Comments of South (Specify) 2 Revisit 4 Comments of South (Specify) 2 Revisit 5 Comments of South (Specify) 2 Revisit 5 Comments of South (Specify) 2 Revisit 5 Comments of South (Specify) 2 Revisit 6 Comments of Specific Comments of Spec		Elementery/Seco	ify only highest	grede completed)	or 5+)	(Giv life.	e kind of N DO NOT	vork done use retired	during most of we	orking			
198. Mailing Address (Stree and Number or Rural Route Number, City or Town, Stete, Zip Code) 201 Brandon G. Nelson/Mother 202. Medical Examiner of Indiana 203. Method of Disposition 199 203. Method of Disposition 199 204. Date signal 14, 199 205. Location 199 20	1			*								imeme)	
Brandon G. Nelson/Mother 20a. Method of Disposition 11 Burilla 2 Chrometion 3 Removal from State 4 Donation 5 Other (Specify) 6 Other (Specify) 7 Other (Specify) 8 Other (Specify) 9 -													
20a. Method of Disposition 19													
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avernue, Rockville, Maryland 20856 23a. Pdrt / Enter the disease, or communities that caused the death. Do not enter the mode of dying, such as cerdiac or reapiretory arrest, Immediate Cause (Final disease or conditions) Immediate Cause (Final disease or conditions) Immediate Cause (Final disease or conditions) Immediate Cause (Final disease)	-	0a. Method of Disp 1 Burial 2 [oosition Cremetion 3	☐Removal from Sta	ate	Place of Dis cemetery, cr	position (A emetory o	ierne of r other ple	Ce) Aug. 1		20c. Loca	tion - City or T	own, Stete
Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Due to (or as a consequence of): Due to (o		Mul	1120	Leen-	M008	46 E	22. Name Robert 800 We	and Addre A. Pu st Mor	ss of Facility Imphrey Fu Itgomery A	venue, Ro	e/Rockv: ckville	ille, In	c. nd 20850–28
Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of the contribution of t	d	disease or condition esulting in death)	n	a. M E	Due to (or es e cons	equence o	f):	ROBLAS	STOMA			5 1/2 YI
1 Yes 2 No 3 Probably 4													
25. Was case referred to medical examiner? 1	-	art II. Other signif	cant conditions	contributing to deat	h but not res	sulting in the	underlying	g ceuse gr	ren in Part i.			,	
25. Was case referred to medical examiner? Yes 2 No	_									24a. Wa	s an autopsy formed?	81	vailable prior to empletion of cause
examiner? Namper of Death 2										1□	Yes 2 🗹	No 1	☐ Yes 2☐ No
27. Manper of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Location (Street and Number or Rural Route Num. City or Town, Stete) 29e. Certifier (Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 29b. Signature end title of certifier 29c. License number 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	2	examiner?	/	Hospital:				Oth					
29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		7. Manner of Death 1 Netural	h 5 Dending	28a. Date of (Month,		28b. Time	of	28c. Injui Wor	y at				ity)
(check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		4 Homicide	determine	ed 28e. Place of building	, etc. (Speci	(fy)				City or To	own, Stete)		
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	2			unci,	LTC,	USAF				-4293-1			
30. Name and address of parson who completed ceuse of deeth (Item 23e) (Type, Print) DOMINIC A. DEFRANCIS M.D. PSC 76 BCX 6916 APO AP 96319	30	0. Name and addre	ess of parson wh	o completed ceuse	of deeth (iter	m 23e) (Typ	e, Print)						

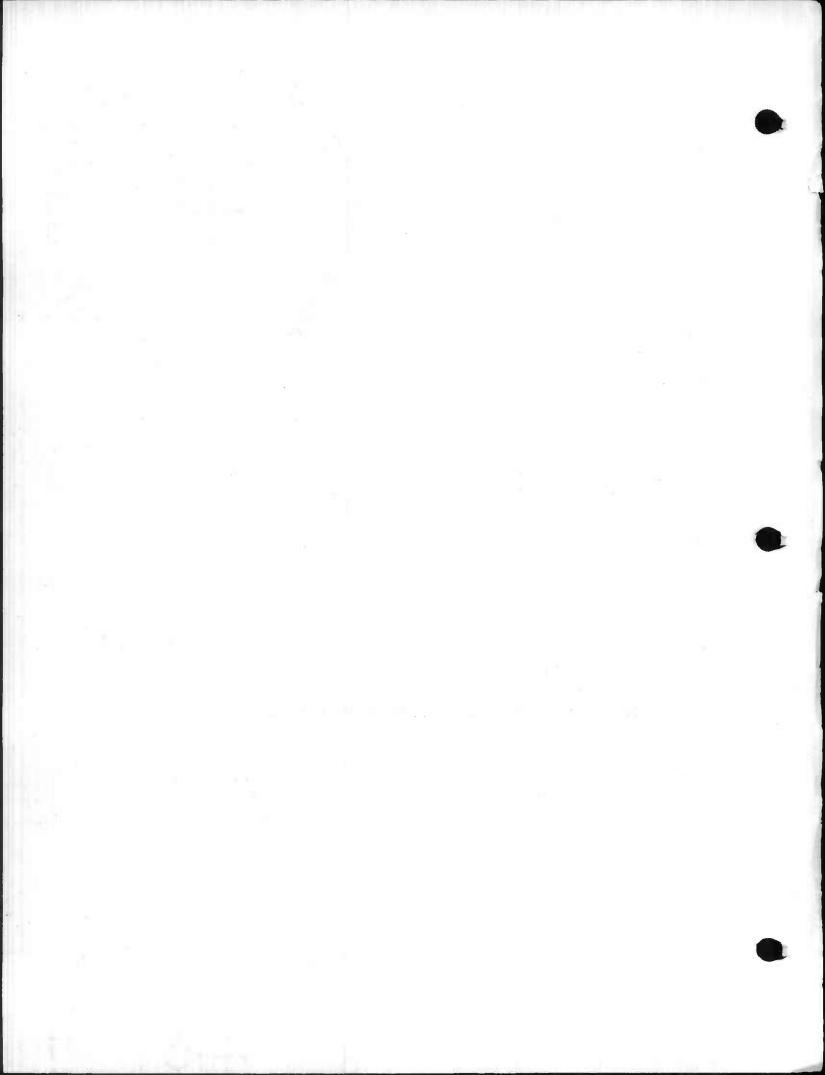


1, 2, 3 should

SALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL THE FUNERAL filed within 72 IPORTANT: II	OR ATTENC DIRECTOR: hours after item 28 Is	After this ce Jeath with th	SIAN: The strifficate has be State D or Item 3	law require is been sig ept. of Hea 23 shows	s that the d ned by the lith and Mei	attending partending p	thysician and prior to bu	uted within completel urial, crema ic event,	y filled in ation, or re	after death by the fune moval. Ical exam	. Page 6 m ral director, iner mus	ay be retain page 5 sho t be notifi	ed by the huld be detacted	ospital or atta	ending physical as the burial	cian. I-transit permi	ermit. Pages	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM			MENTAL HYGIE					
19	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3.	TIME OF DEATH		
- 01	MARGARET REGINA	A NORTON				AUGUST 15	199	9 EAR	2:45AM M		
8	4. SOCIAL SECURITY NUMBER 160-10-1880	1 □ M 2 🂢 F 95	n yrs. lasi birthday) IF U YRS. MONT	NDER 1 YEAR THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BUTTH (Month, Day, Year) JAN. 28,			NCE (State or Foreign YLVANIA		
TOR	9a. FACILITY NAME (If not institution, give since the second of the seco			CITY, TOWN OF	SPRING	ATH		GOMER			
DIRECTOR	10e. STATE 10b. COUNT	NTGOMERY		WN OR LOCATE				1	d. INSIDE CITY LIMITS? YES 2 X NO		
FUNERAL	100. STREET AND NUMBER 3700 INTERNATION	AL DRIVE	I	10f.	ZIP CODE 20906		USA	EN OF WHA	T COUNTRY?		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, spe-		IIC ORIGIN? (Specify) n, Puerto Rican, atc.)	ba or No-	Black, W	American Indian, Inita, atc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	16a. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir HOMEMAKE	lone during mos red.)	of working	166. KIND OF B		USTRY			
BE COM	17. FATHER'S NAME (First, Middle, Last) JOHN DORRIAN				ANNA (
5	19a. INFORMANT'S NAME (Type/Print) LEO JOHN NORTON,	JR. (SON)				Route Number, City or R. OLNEY,					
	20a. METHOD OF DISPOSITION 1 Dunier 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	20b.	PLACE AND DATE OF DIS	SPOSITION (Nan	ne of	DATE 20c. L	OCATION — (City or Town,	Stata VIRGINIA		
d	21 SIGNATURE OF FUNERAL SERVICE LE		are		ADDRESS OF FA		NALDI	1180	O NEW HAMP		
\dashv	23. PART I. Enter the diseases, or	complications that caused	the death. Do not e				-		Approximate		
	shock, or heart feliure. IMMEDIATE CAUSE (Final	a. Congus on eause on	och line.						interval Between Onset and Death 445 Several years		
CERTIFICATION	lh. and leas in a										
AL	PART II. Other significant condition	na contributing to death be	ut not resulting in th	e underlying	ceuse given in		N AUTOPSY ORMED?	AM CC	ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE		
PHYSICIAN: MEDIC	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF DE	ATH YE	S NO		2 10		F DEATH?		
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	QT	26. PL/	CE OF DEATH (Ch	eck only one)					
	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	Nursing Home 28c. INJU WOF	RY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCC	URED			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Speci	— A1 home, farm, street,		S 2 NO	281. LOCATION (Stree City or Town, Stat	(and Number	or Rural Roul	e Number,		
COMPLETED		SICIAN: To the best of my knowle									
88	296. SIGNATURE AND TITLE OF CERTIFIE			1	29c. LICENSE NUN D 510	ABER	29d. DATE	SIGNED (M	onth, Day, Year)		
٩	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DEA	NTH (ITEM 27) (Type, Print)	Ave					10/11/		
	31. DATE FILED (Month, Day, Year) AUG 2 0 1990	32. REGISTRAR'S SIGNA	ATURE /	paks		3	,				
									DHMH-18 Rev 1/89		

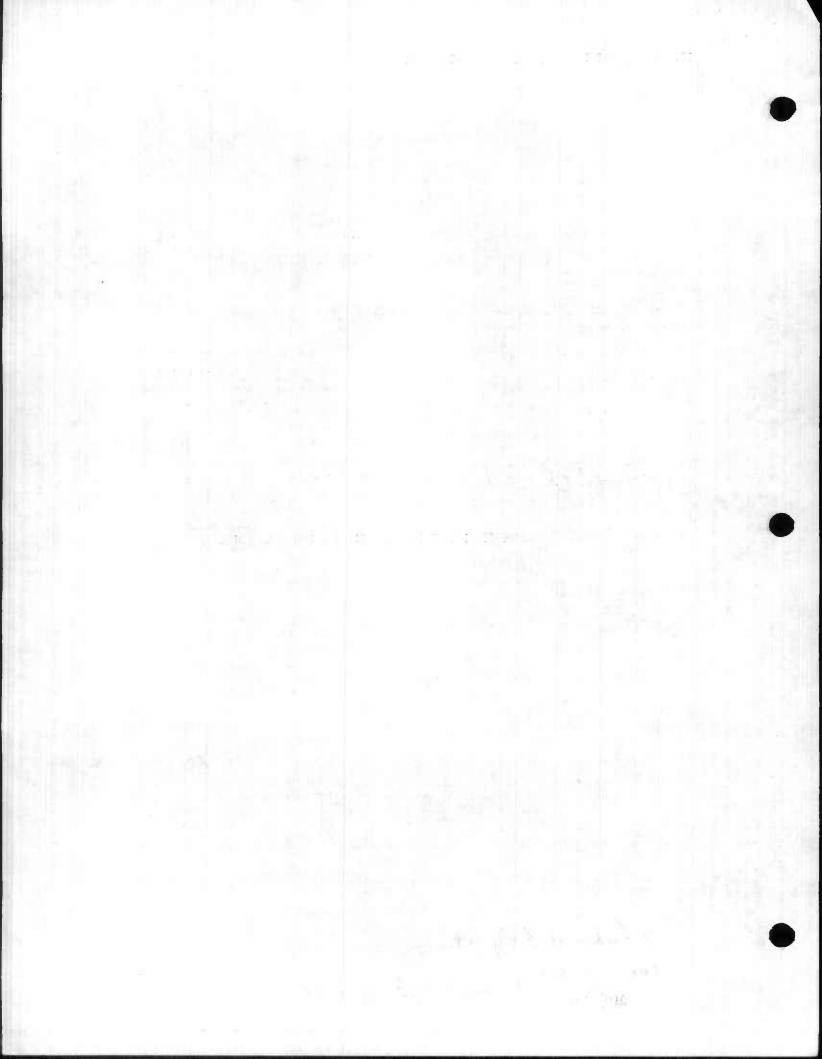


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State of Maryland / Department of Health and Mental Hygiene

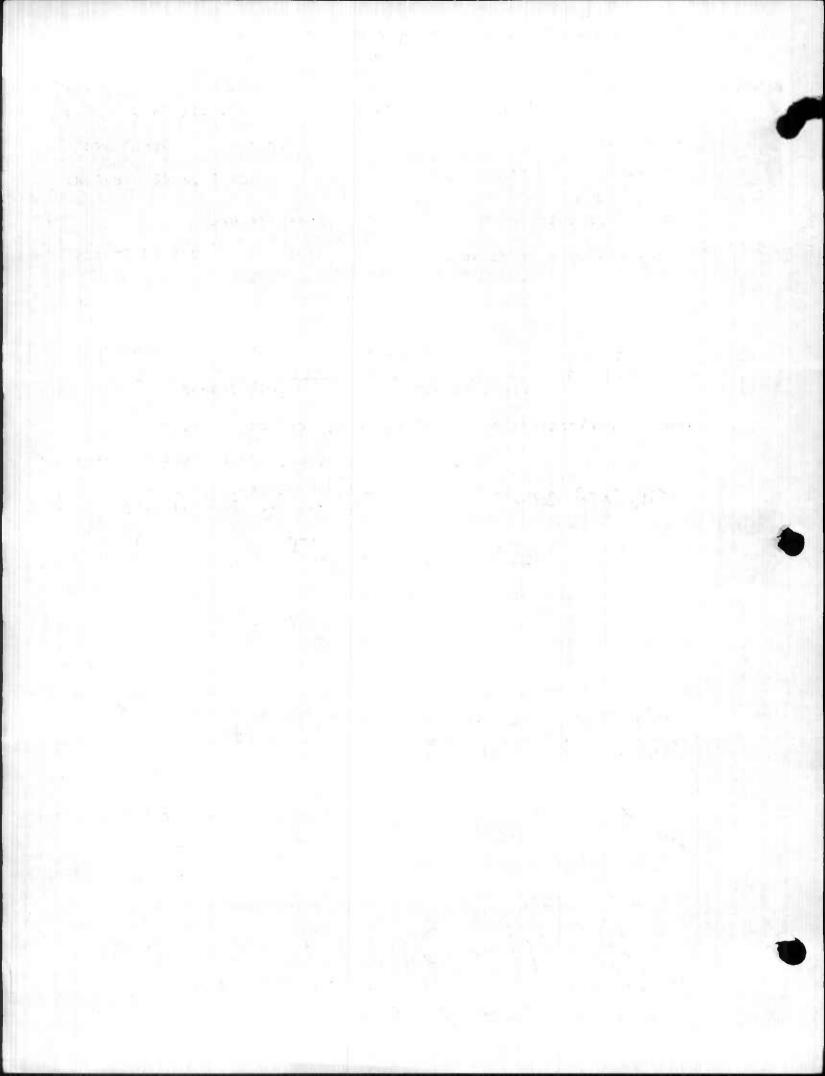
3	9	604	0	3	0
	fm.	1	5		

onald Euger AMEND	ITEMS: #23 PART I, 27 P	ER MEO G774 9-1	-99 WR.Cel	tificate of I	Death	2. Date of Deat	eg. No.	1 2	3. Tims of Death
Physician	Ronald Eugene					Month	Day	Year	
/Medical	4a Facility Neme (If not institution, give				lb. City, Town, or Loc	August	15, 19		6:20 P.M.
Examiner	14116 Harrisvill				Mt. Airy		Frede		
Funeral	5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	6. Dete of Birth (Month, Day,			e (Stete or Foreign
Director	215-64-2320 15 Usuel Residence of Decedent	3 M 2□F 4	3 Yrs.	Months Days	Hours Min.	Marchl	9,195	6 Country)	MD
with the Marytand s or 28a-f show be notified at Director	10a. State 10b. County MD Freder		City, Town or Lo						Inside City Limits 1 Yes 2 XNo
or 28e-ts be notified Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of V		
ath w	14116 Harrisv			2177			Unite		
hours after death values, or thems 234 at Examiner must be by Funeral	11. Marital Status 1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		Ves Decedent of H i Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		- American (k, Whita, etc.	
ed within 72 ho ygiens. wr then "naturi t, the Medical I	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	lent's Usuel Occup kind of work done o OO NOT use retired	during most of working	10	16b. Kind of Bu	siness/Indust	iry
the the	Elementery/Secondery (0-12)	College (1-4or 5+)		Roofer			Cons	struc	tion
d offser d offser event, Be C	17. Fether's Neme (First, Middle, Last)				16. Mother's Name	(First, Middle, N	Aaiden Sumem	e)	
d Ments marked martic ev	Henry James Na 19e. Informent's Neme/Reletionship (7		10h Maitin	a Address (Street	Alice	Estell			orda)
antith and a 27 is a traus	Alice E. Naill								
116	20e. Method of Disposition			sition (Name of natory or other plea	cord Rd.	- 7	20c. Location -		
tant: If the	1 Burial 2 Cremation 3 II)	cemetery, cren	Cremat	ory 8/1		Hampst		
Department of the partment of	21. Signature of Funeral Service Licens	. Schen		Name end Address Vers Fur	ss of Fecility neral Ho		illis tminst		
nding physician and see as the bunkl-transit	disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to	o (or es e consequence o conseq	uence of):	JIOVASCULAR	UTSEASE			
e attendin ed for use sician/M	Dod II. Other similians conditions as		and Dodd	OOD Didas	haasa	andhuda da dh	0.0000000000000000000000000000000000000		
igned by the attending be detached for use a by Physician/Me	Pert II. Other significant conditions co	ntributing to death but noi i	esuiting in the ur	idenying cause giv	en in Pert I.		oacco uee cor es 2 No	3 Probab	e cause of death?
should should	6-92					24a. Was er perform		svallel	eutopsy findings ble prior to letion of cause th?
page 2						1000	s 2 No	1 NO Y	es 2 No
certificate rector, pag	25. Was casa referred to medical				26. Place of Deeth	(Check only on			
nis certific	examiner? 1∑Yas 2□ No	Hospitel: 1 Inpatient 2	☐ ER/Outpatien	3 DOA Oth				er (Specify)	
£ 7	27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of	28c. Injun Work		8d. Describe ho		1-1-11	
after death. I Director: Afte din by the fune	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - Al building, etc. (Spe		eet, fectory, office	2	8f. Location (Sti City or Town	reet end Numb n, Stete)	er or Rural Ro	oute Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my k iner: On the basis of exami end menner steted.	nowledge, deeth	occurred et the timestigation, in my of	ne, date end place, a pinion, deeth occurre	nd due to the ca d at the time, da	ause(s) and me ate and place, a	nner es state and due to the	d. e cause(s)
omple Me	29b. Signature and title of certifier			29c. License	e number	25	9d. Date signed	(Month, Day	y, Year)
s = 0	Theoden Me	King mg			.C.M.E.		August	1117	
	THEMORE MU	ompleted deutse of death (II		.11 Penn	Street, Ba	altimore	e, Mary	land 2	1201
State Registrar	31. Dete filed (Month, Day, Year) AUG 2 0 199	32. Rødistrer's Sig	inature \mathcal{G} .	Spark	2				



State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	ina moman m	Reg. No.	2 61201	7
	Dharaini		Decedenl's Name (First, Middle, Last)	2. Date of D	eath	3. Time of Deat	th
	Physici /Medi		MARJORIE M. NICKERSON	AUG.	12, 199	9 1230	
1	Examir			n, or Location of Dea	th 4c. County of	of Deeth	
				ırlock		chester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year It Under 2 Add Months Days Hours 77 Yrs.	Min. (Month, D		Birthplace (State or For Country)	reign
			220-01-7494	May 2	7,1922	Maryland	
	yland		10a. State 10b. County 10c. City, Town or Location			10d. fnside City Lin	mits
	e Mar	ctor	MD Dorchester Feder	alsburg		1 □ Yes 2 □	No
	or 28	Oire	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?	
	ath w	Funeral Director	6741 Bailey's Store Road 21632			States	
	er de Rem	une	11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin If Yes, specify Cuben, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	0- 14. Race Black	- Americen Indian, k, White, etc.	
20	a sa f	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Giva 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify:	White	
21215-0020	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, if a Medical Evanties must be notified a	be	15 Decedent's Education 16a Decedent's Heigh Occupation		16b. Kind of Bus		
213	hin 7 nn 7n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	of working			
7	ad wit	Соп	Seamstress		Sport	swear	
aryland	should be filed vind Mental Hygie marked other I umatic event, it	Be		s Name (First, Middle		3)	
Z	should nd Men marke	70		gie Coop			
Mai	ith and ?7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number)			State, Zip Code)	
e,	os 1 and of Health frem 27 other tr		Kenneth Hurlock/Brother PO Box 520, Hurl 20a. Method of Disposition (Name of	OCK, MD		City or Town, Stete	
altimore,	ages ant of tt: If ft		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) Eastern Shore Vets.			k, Marylan	Ч
T T	pemit. Pages Department of Important: If if eny injury or once.		21. Signature of Funeral Service Licensee 22. Name end Address of Facility	0/10	nui i oci	x, marylan	u
ä	Ded printer		Framptom-Hawk	ins-Esko	ow Funei	ral Home,	PA
			23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter the mode of dying, such es ca shock, or heart failure. List only one cause on each line.	t., Fed ardiec or respiretory	eralsbui	Approximete	
	Physician		snock, or heart failure. List only one cause on each line.			Interval Between Onset end Death	
7	/Medical	Н	Immediate Causa (Finat disease or condition resulting in death) a. Electolyte Decampent			12 2005	
	Examiner		resulting In death) Dua to (or as a consequence of):			30793)
	be it	Examiner	Dehndration			weeks	
	The law requires that tha death certificata be assocuted tto has been signed by the attanding physician and page 2 should be detached for usa as the bunal-transit	xan	Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Causa (Disease or Injury C. Meta-Static Lung C.	1		0	
68760	siciar siciar buni			A		2 YAS	7
68	ntificate ng phy nas the	Medical	resulting In death) Last Due to (or as a consequence of):				
Box	andin usa		d			/	
	death	sicie	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld	tobacco use cont	tribute to the cause of dea	eth?
<u>о</u>	v requires that tha death cer been signed by the attandir should be detached for usa	Physician/				3 robably 4 Unkn	
	ignec be d	by	11716 1000 1717 100 1100 1100 1100 1100	Tal. Was			
Records,	negui neen s	Completed	Gak-15.+3 Colitic	24a. Was	an autopsy ormed?	24b. Were eutopsy finding available prior to	
Sec	has b	dE		- 1		completion of ceuse of death?	
				10	Yes 2500	1 □ Yes 2 3446	
Vital	Attending Physician: The law is death. ector: After this certificate has by the funeral director, page 2	o Be	Hospital:	f Death (Check only		stants Ham	^
5	Phys r this aral di	-	1 Yas 2 ANO POSPIGE: 1 Inpatient 2 ER/Outpatient 3 DOA Ornar: 4 Nursi 27. Manner of Death 28e. Date of Injury 28b. Time of 28c. Injury at	ing Home 5 ☐ Res	dence SCOTTE		е
Division	ding fith.	Certification:	The Naturat 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Vest 2 No.				
N N	Attendiar death.	Iffice	3 ☐ Suicide 6 ☐ Could not be detarmined 28e. Place of Injury - At home, farm, straet, factory, office	28f. Location (Street and Number	r or Rural Routa Number,	
٥	rs after de la Direction by I	Cert	building, atc. (Spacify)	City or To	wn, State)	-	
	To the Hospital or A within 24 hours after To the Funerel Direct Compietely filled in b	edicai	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and processing the control of the control	placa, and dua to tha	cause(s) and man	iner as stated.	
	the the mpiat	Med	and manner stated.	occurred at the tane,	- 1		
	F.≱ F. 8	7	29b. Signature and the of certifier 29c. License number	15	290. Date signid	(Month, Day, Year)	
			30 Name and Adverse of access who are	010	0/2	///	
			30. Name and address of person who complated causa of daath (Item 23a) (Type, Print)	10 711	2		
	Sta	te	DR. Lors Narr & Aurora St. Cambridge, No. 31. Date filed (Month, Day, Year) 32. Registrer's Signature ALIG 17 1999 DR. Lors Narr & Aurora St. Cambridge, No. 32. Registrer's Signature	· U = 10/	J		
	Registr	-	AUG 1 7 1999 Server B. Sparks				



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate c	of Death		Reg. No.	-	- File Division
	Physician /Medical		na (First, Middla, La osephine	c C			PICARI		2. Data of D Augus		9 ^{ygar}	3. Time of Death 7:30am
	Examiner	4a Fecility Nama Frede	(If not institution, giverick Memo	rial Ho	spital			4b. City, Town, o	r Location of Daa LCK		of Deeth	
	Funeral Director	5. Sociel Security 129–16–	9753	ex □M 2∏F	7. Age (In yrs. I 7.5	lest birthday) Yrs.	ff Under 1 Ye Months Da			av. Yaar)	9. Birthi Cour Ne	placa (Stata or Foraign ntry) ew York
	inyland	Usuel Residance	10b. County		10c. City	, Town or Lo	cation					10d. fnsida City Limits
	oto oto	NY	Suffolk		L	ake Ro	nkonkon	na				1 X Yas 2 □ No
	or 28e-f s be notified	10e. Street and N	umber				10f. Zip Cod	e		10g. Citizen of 1	What Coul	ntry?
	th wi	46 Midl	and Boule	vard			1177	9		U.S.A		
020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28=4 show other traumatic event, fire Medical Examinational be notified at To Be Completed by Funeral Director	3XXWidowed	rriad 2 Married 4 Divorced	12. Was Dece Armed For 1 Tas If Yes, Give Yaar or Da	cas? 2∭ No e		Was Decedant of Yes, specify C	of Hispanle Origin? (uban, Maxican, Pue No <i>Specify:</i>	Specify Yas or N erto Ricen, atc.)	o- 14. Red Blac Specify	ck, Whita,	cen Indian, atc.
5-0	72 h	/Sn4	15. Decedant's Ed	ducetion		16a. Dece	dant's Usual Oc	cupation na during most of w	odkina	16b. Kind of B	usinass/In	dustry
21215-0020	filed within 72 ho Hygiene. other than "natura ent, fre Medical e Completed	Elementary/Sec		Collega (1-	4or 5+)	lifa.	kkeeper	tired)	orkary	Auto	Sale	2S
pu	be filed tal Hygid d other event, II	17. Fathar's Nema	(First, Middla, Last))				18. Mothar's N	ama (First, Middle	a, Maidan Suman	na)	
Maryland	Mental Mental or series of or series	Frances	co Sipala					Alfonzi	a Scheml	ora		
ary	should bend Ment e marked	19a. Informant's I	Name/Ralationship (Type, Print)		19b. Maille	ng Addrass (Str	aat and Number or I	Rural Route Numi	ber, City or Town,	Stata, Zij	p Code)
	1 and 2 Health e em 27 le	Richard	Picari -	Son		46	Midland	Blvd. La	ke Ronko	onkoma,	NY 1	11779
Baltimore,	permit. Peges 1 en Department of Heal Important: If Item 2 any injury or other pace.	20a. Mathod of Di 1 X Burlal 2	sposition	Ramoval from S	itata	lace of Dispo amatary, crai	sition (Nama of matory or other	piace)	Data	20c. Location	City or To	
ţ	tant:		5 ☐ Other (Specificant Sarvice Licer		Ca			nal Cem.	8/16/99		rton,	, New York
	eded in the state of the state	Ma	tha disaasa, or com art failura. List only	D. W	used tha daath	7	211 Lee	-	11s Chur	ch, VA	2204	Approximata Intarvel Between Onsat and Daath
	/Medical	Immediata Causa disaasa or conditi	(Final	Mu	ltisyst	em Deg	generati	ion			1	Years
	Examiner je	rasulting in death)	sh:	Dua to (or y-Drage	ras a consec er Sync						
,0	tificate be executed g physicien and es the burial-transit	Sequantielly list of it any, laading to ceuse. Enter Und Causa (Disaasa of	onditions, immadiata larlying	b	Dua to (or	as a consec	quance of):				1	
x 68760,	certificate be executed ding physicien and ise es the burial-transit Wedical Examil	that Initiated avan	ts Last	d.	Dua to (or	as a consec	uance of):		The state of			
Bo	death c			<u>.</u>							1	
P.O.	the day the sched	Part II. Other sign	e Orthosta				ndarlying causa	givan in Part I.		tobacco use co Yes 2□XNo		to the cause of death?
Records,	been s should should									s an autopsy formed?	6/	Vara autopsy findings veileble prior to completion of ceuse daath?
	an: The law rtificate hes stor, page 2								1 🗆	Yas 2 No	1	□ Yas 💥 No
of Vital	ysician: is certifica director, To Be (25. Was cesa rafa axaminar?		Hospitai:			25	Other:	eath (Chack only			
	£ £ =	27. Manner of Dea		28a. Data o (Month	patiant 2	ER/Outpatier 28b. Time o Injury	28c. I	njury et Nork?	Homa 5 Ras	eldance 6 Oth how injury occur		(hy)
Division	P# 2 = F	3 ☐ Sulcida 4 ☐ Homlcida	6 Could not be datermined	Zoa. Place	of Injury - At ho g, atc. (Specify	ma, farm, str	eat, factory, offi	ce	28f. Location City or To	(Street and Numi own, Stata)	ber or Run	ral Route Number,
	Hospital Hos	29a. Cartifiar (Check only one)	1☐ Certifying Ph 2⊠ Medical Exam	ysician: To tha t niner: On tha ba- and menn	sls of axaminat	wledga, daati lon and/or in	n occurrad at the vastigation, in m	a tima, data and pla ny opinion, daath oc	ce, and dua to the curred at tha time	a causa(s) and m , data and place,	annar as s and dua t	stated. to the cause(s)
	To the within 2 To the comple	29b. Signatur in	d title of certifiar) 0	4	^		anse number 35164		29d. Date signe August		

State Registrar

30. Name and address of person who completed ceus of the (Itam 23a) (Type, Print)

Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703 32. Røgistrar's Signatura

C- 12 James

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Barbara K. Panagos Aug. 14, 1999 5:05AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5901 Montrose Road #1500S Rockville Montgomery H Under 1 Ve If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 1 M 2 F Days 62 Sept. 19, 1936 Pennsylvania 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 5901 Montrose Road #1500S U.S.A 20852 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) John Kookley Catherine Mrowca 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George M. Panagos-Husband 5901 Montrose Rd. #1500S, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 8/18/99 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Joseph Gawler's Sons INC, 5130 Wisconsin Ave. deanbatter NW, Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Onset and Death IVC Thrombosis 2 Months Due to (or as a consequence of): Trousseau's Syndrome 2 Years Due to (or as a consequence of): Peri Ampullary 4 Years Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

28e-f

Name 23a or

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: If Hem 27 is marked other than "natural", or Hea any Injury or other traumatic event, the Medical Examines

Baltimore, Maryland 21215-0020

with the Maryland

5. Social Security Number

578-48-9514

10e Street and Number

Maryland

Usual Residence of Decedent

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia þ Completed 1 Yes 2 No 1 Tyes 2 No 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Cartifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature

D45880

29d. Date signed (Month, Dey, Year)

30. Name and add les of person who completed cause of death (Item 23a) (Type, Print)

Hwang MD., Leon 10400 Connecticut Ave. #606 Kensington, MD 20895

State Registrar

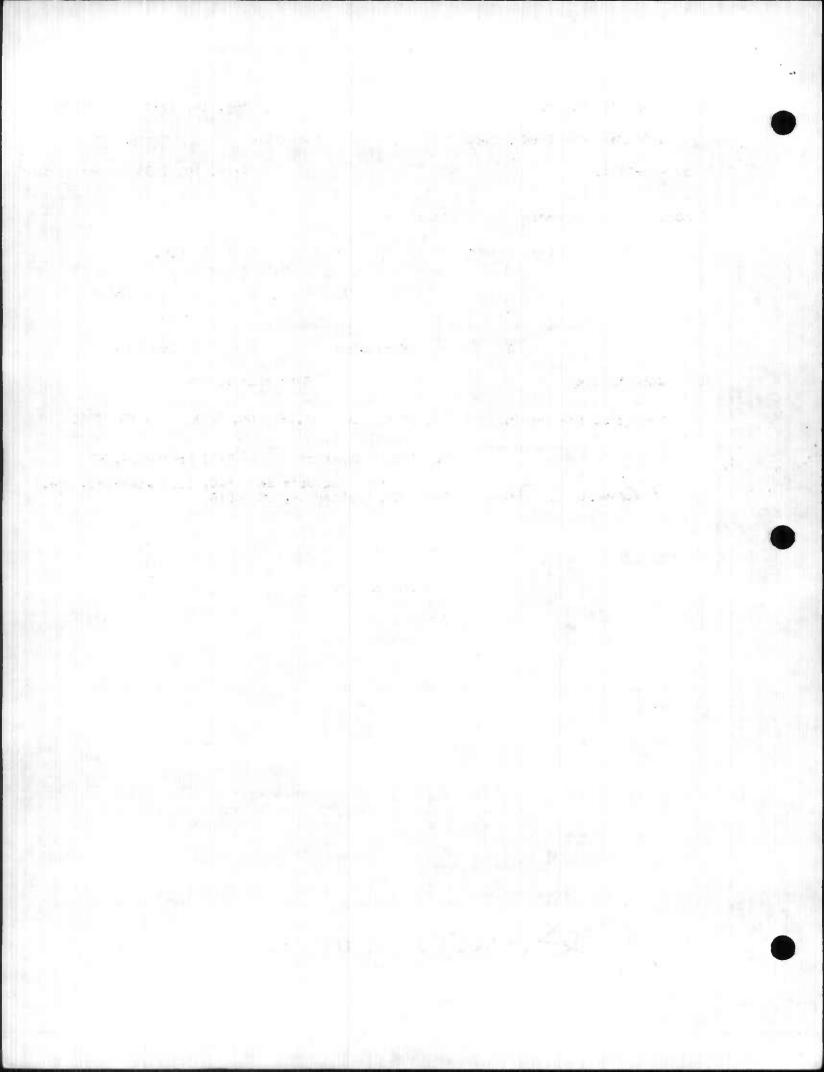
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31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 20 1999

DHMH 16 Rav 6/95

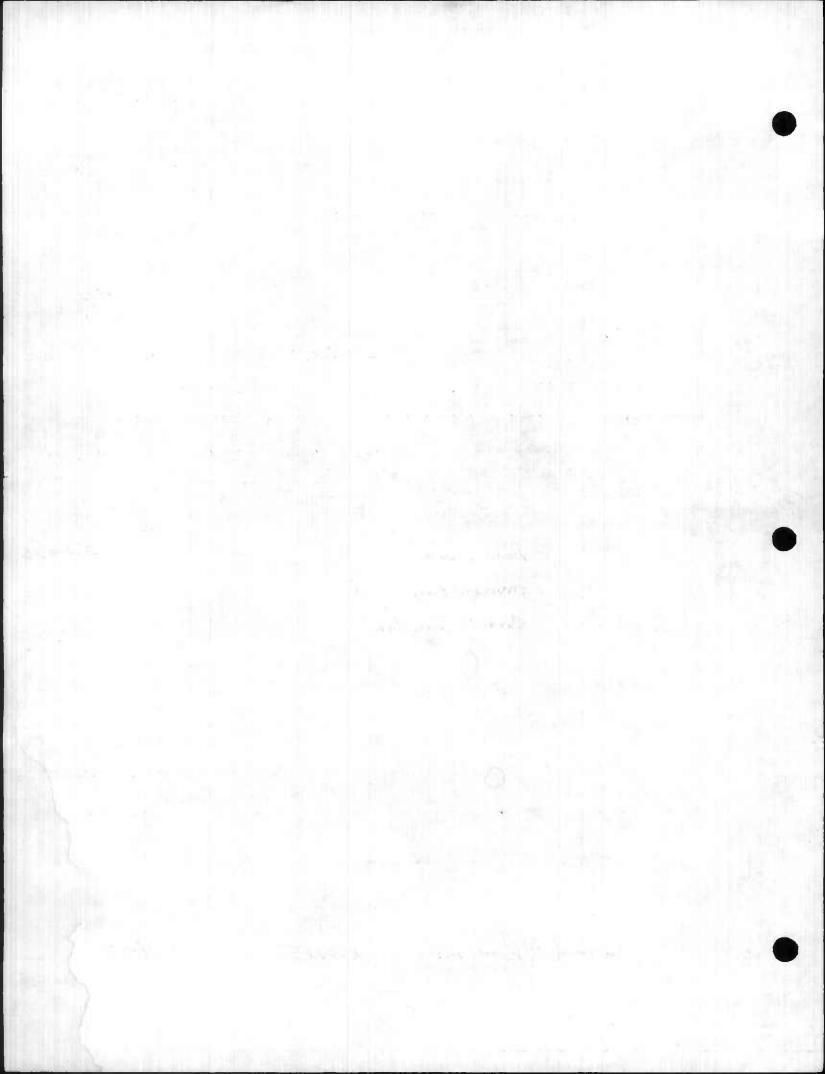
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The law requires that the death certificate be executed the burial-transi Box 68760, physician 88 080 P.0. of Vital Records, page 2 should After this certificate has or Attending Physician: funeral Division death. the 1 To the Hospital or Attend within 24 hours after deal To the Funeral Director: filled in by



State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.	6	1646
		1. Decedent's Neme (First, Middle,	Last)					2. Dete of De	eth		3. Time of Death
	Physician	JAMES	B. PH	ILLIPS	TR			AUGUS	T 18,	Year 1999	10:00 P
	/Medical Examiner	4a Facility Neme (If not institution,			O IX		4b. City, Town	, or Location of Deat			
		Holy Cross	Hospital				Silve	r Spring	MON	rgom:	ERY
	Funeral Director	5. Sociel Security Number 242-44-3361	6. Sex 7. Ag 1 □XM 2 □ F	e (In yrs. last bir	Yrs. If Unc		If Under 24 Hours	Hrs. 8. Dete of Bin (Month, Det Julvi	2, 1932	9. Birthpl Count N	lace (Stete or Foreign try) Carolina
	70	Usuel Residence of Decedent									042022114
	Manylan I show led at tor	MD Montg	omery	10c. City, Town	n or Location Lver S	prin	na			10	0d. Inside City Limits 1 Yas 2 XNo
	with the Mary s or 28a-f sh be notified. Director	10e. Street and Number	4			Zip Code	- 9		10g. Citizen of W	Vhat Coun	try?
		13100 Hugo				0906			U.S.A		
020	72 hours after death value in the same same same same same same same steel Examiner must teel by Funeral	11. Merital Status 1 Never Married 2 Merrie 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 X Yes 2 1 Yes, Give Yeer or Detes:				Hispanic Origin pan, Mexican, F Specify:	? (Specify Yes or No Puerto Rican, etc.)		a - America k, White, e : Wh:	etc.
5-0	72 hz fical	15. Decedent's (Specify only highest		16a.	Decedent's Us	suel Occu	pation	f working	16b. Kind of Bu	siness/Ind	lustry
21215-0020	od within 72 ho ygiene. we then "netur it, the Medical. Completed	Elementary/Secondery (0-12)	College (1-4or 5	j+)			during most of od		NAS/	4	
D		17. Father's Name (First, Middle, L.	<u> </u>		COILCI	uc cı	7	Neme (First, Middle			1 1 2 1
an	d be find the find th	James B. P.	hillins. S	ir.			E372	ottenb	ura		
Maryland	shou man	19a. Informent's Neme/Reletionship		-	. Meiling Addre	ess (Stree		or Rurel Route Numb		Stete, Zip	Code)
ž	100 a	Isabella J.									
e,	Hoa Hoa	20e. Method of Disposition		20b Place of	Disposition (A	lame of		Date	20c. Location -		
altimore	Page ment of lant: If I	1 Burial 2X Cremetion 4 Donation 5 Other (Sp.	ecity))	Metro		an F	'/Serv	8/19/9	9 Alexa	ındr:	ia, VA
Bal	Depart Depart Import any in	21. Signature of Funeral Service L	X. Ma	melei	SN	OWDE	ess of Fecility IN FUNI	ERAL HOM			
		23a. Pert1. Enter the disease, or of shock, or heert fallure. List of	complications that caused	the death. Do no							Approximate intervel Between
	Physician		_								Onset and Death
	/Medical	fmmediate Cause (Final disease or condition	. Preun	uma							2 weeks
	Examiner	resulting in deeth)	a	Due to (or as a	consequence o	of):				1	
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	tificate be executed g physician and as the bunal-transit	Sequentially list conditions,		no 54 p		of):					
00	ounial will	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Cardea	'c Thoug	plant	-					
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00	been s should							pen	ormed?	COF	mpletion of cause death?
Re	The law requir sate has been s page 2 should							10	Yes 2 No		Yes 2 No
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o	ding F. After a funer	1 ☑Neturai 5 ☐ Pending 2 ☐ Accident Investige		y Year)	njury M		ork?]Yes 2∐No				
Division	or Attending after death. Director: After d in by the fune certification	3 ☐ Suicide 6 ☐ Could no	and 286. Piece of inju	ury - At home, fe	rm, street, fact	lory, office) r		Street end Numb	er or Aure	I Route Number,
ă	tal or Attending P rs after death. at Director: After t led in by the funers Certification:	4 Homicide	building, etc	c. (Specify)				City or To	wn, Stete)		
	Hospi 24 hour Funer stely fill	29e. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination and	dor investigati	ed at the t	ime, date and p opinion, death	place, and due to the occurred at the time.	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
	within To the comple	29b. Signature and title of certifier	and mainter ste			29c. Licen	se number		29d. Dete signed	d (Month,	Day, Year)
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	15	30. Nema and address of person w	7 / Wen	14D	(Time Brint)	1) 22	775		8.19	7/	
		Frederick	G. BARK N		5454 W	ica	AU	Suite 1	345 Ch.	ULPI	LASE MO 20815
	State			ar's Signeture	107 00	13 41 1	110 1100	2 200161	- 13 0/0	10	
	State	31. Date filed (Month, Day, Year)	199 Sene	va /	9 /	200	1				



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1, 8/19/99, BMW, Montg. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 4:35 P august 11, 1999 Penaloza D. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOPKINS HOSPITAL JOHNS BALTIMUZE CITY H Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F None Director Boliva Usual Residence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Virginia Fairfax Fairfax 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 10112 Cavalry Drive 22030 Bolivia Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2X No If Yes, Give Yeer or Detes: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after Never Married 2 Merried Baitimore, Maryland 21215-0020 1 XYes 2 No Specify: Bolivian Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A permit. Pages 1 and 2 should be file Department of Meath and Mental Hy Important: If Nem 27 Is marked othe any Injury or other treumstic avent place. 17. Fether's Name (First, Middle, Last) 16. Mother's Neme (First, Middle, Maiden Surneme) Be Carlos Penaloza Miriam Mercado 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlos Penaloza/Father 10112 Cavalry Dr., Fairfax, Virginia 22030 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removel from Stete Fairfax Memorial Park 8/14/99 4 Donation 5 Other (Specify) Fairfax, Virginia 22. Name and Address of Facility VIENNA FUNERAL HOME, INC. 21. Signature of Funeral Service Licen 171 W. Maple Ave., Vienna, Va. 22180 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Approximete** Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pneumania disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner taxia languectasia physician and the burial-transit the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last Due to (or es e consequence of Box 68760. Physician/Medical Due to (or as e consequence of): 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal Failure The law requires that Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s 2 No 1 Yes of Vitai Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manger of Death 1 Deatural 2 Accident 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? After Division 5 Pending investigation or Attending s after death.

f Diractor: Aff 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide

To the Hospital within 24 hours a To the Funeral Completely filled Hospital

State

DHMH 16 Rev 6/95

31. Dete filed (Month, I Day Year) Registrar

29a. Certifier (Check only one)

29b. Signaturea

title of ce

edical

Michelle Smith 600 North Wolfe Street 32. Registrer's Signature 1999 comer

of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21287

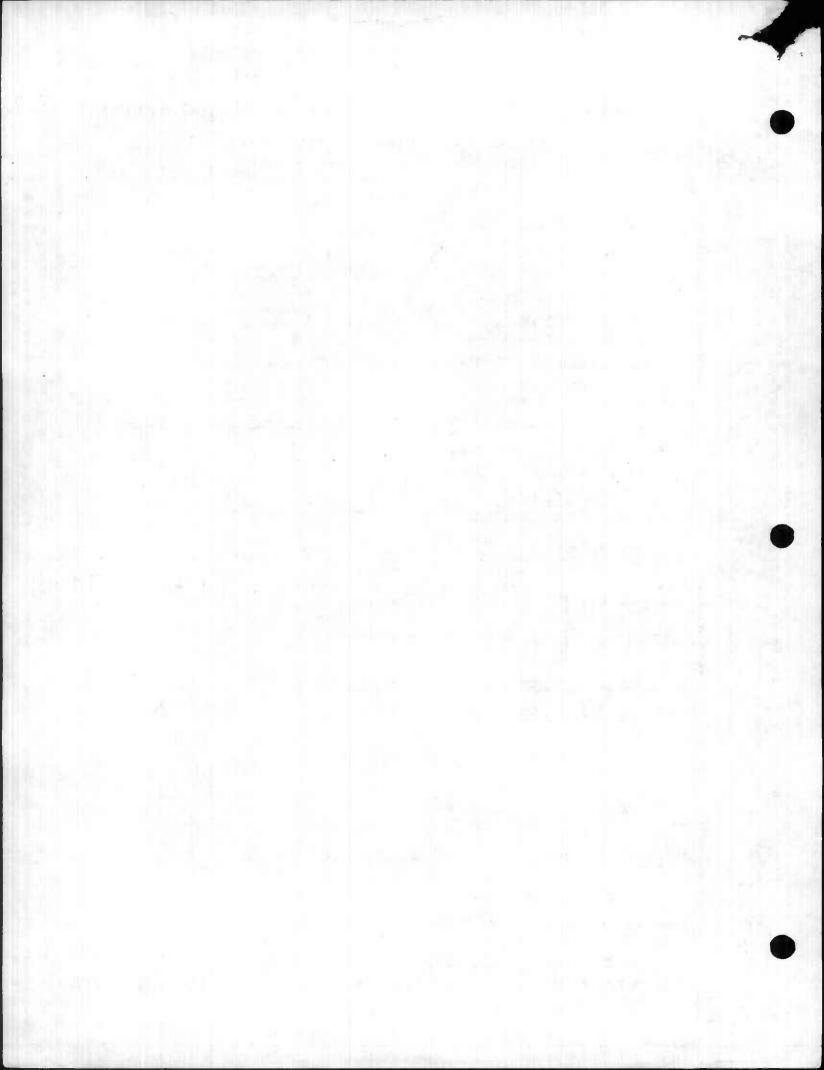
Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number

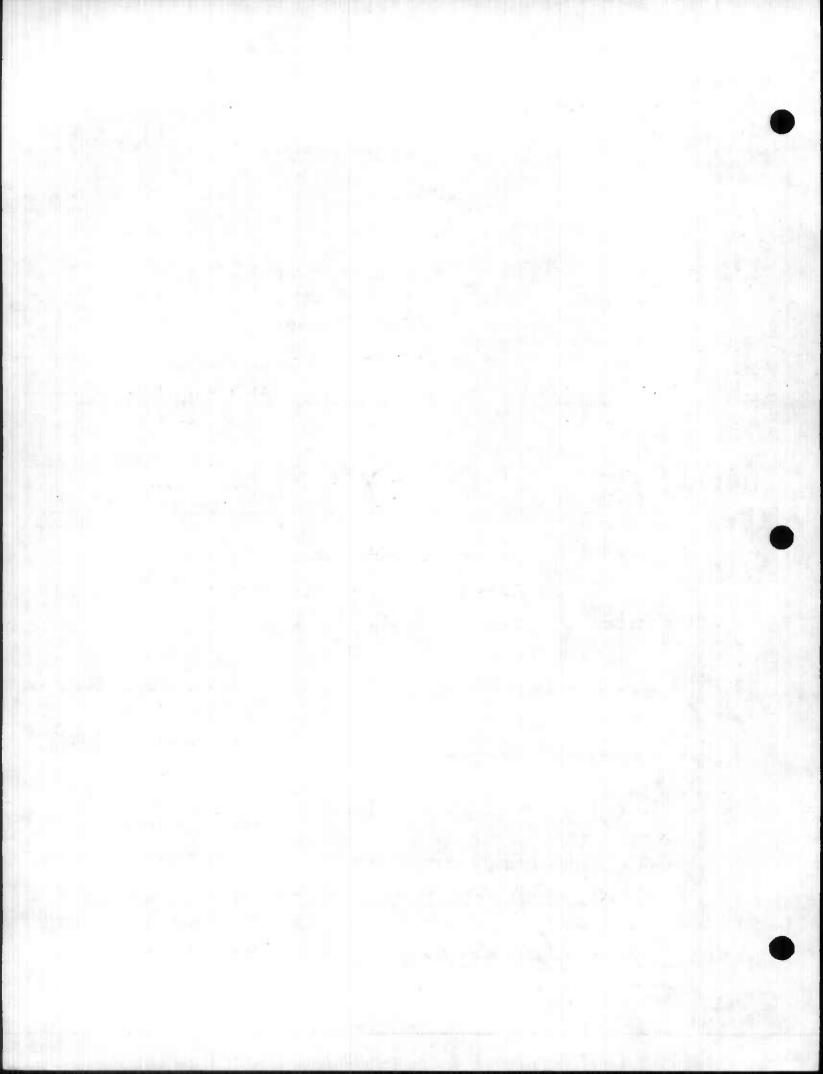
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29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

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	/Medica		Francis Jo 4e Facility Name (If not instit			arl				4b. City, Town, or I		17, 19	ty of Death	11:55	AM
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	ter death with the Marylan Nerms 23st or 28st 6 how ther must be notified at	Funeral	11. Marital Status		12. Was Deceder Armed Forces	s?	,S. 13.	Was Deced	dent of h	dispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)	o- 14. Ra	ce - Americ ack, Whita,		
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Maryland	은 DE	_	19a. Informant's Name/Ralat				19b. Maili	ing Address	(Street	and Number or Ru					
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Baltimore,	Depa mpo mpo mny lr		21. Signeture of Funerel Ser	vice Licens	00	1_	Fr	2. Name en Cancis	d Addre	Collins	Funeral	Home.	Inc.		
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0	the de	Physicianym	Part II. Other significant con	ditions co	ntributing to death	but not res	ulting in the u	ınderlying c	ausa gi	ven in Part I.	23b. Did	tobacco use c	ontribute t	o the cause o	f death?
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	17		30. Neme and address of per	son who do	ompleted cause of	death (Item	n 23a) (Type,	Print)				T			
			Edward J. R:	ichar	ds, M.D.	1	0301 G	eorgi	a Av	renue #20:	3 Silv	er Spri	ng.MD	20902	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month August 15, 1999 Peterson /Medical Earl C. 11:50 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☑ M 2 🗆 F Months Days 579-44-1683 88 Dec. 7,1910 Ohio Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Insida City Limits Director 1 ☐ Yes 2 ☒ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 Funeral 1615 Ladd Street USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: by If Yes, Give Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer Federal Highways 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Peterson Anton Stella Spell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Peterson (wife) 1615 Ladd Street Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/19/99 Silver Spring, Maryland 21. Signatura of Funeral Service Licens 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Onset and Death Immediate Cause (Final METASTATIC CANCER disease or condition resulting in death) Due to (or as a consequenca of) Examiner METASAAL CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) MEAD & NECK (AMEN Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injun 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bethesda MD 20815

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Hospital or Attending Physicien: 24 hours efter death. Funerel Director: After this certifice

To the Hospital of within 24 hours of To the Funerel D completely filled in

Box 68760.

P.O.

Division of Vital Records.

The law requires that the death certificate

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the Medical Examiner must be notified at

with the Maryland

death

filed within 72 hours efter

Peges 1 and 2 should be

Baltimore, Maryland 21215-0020

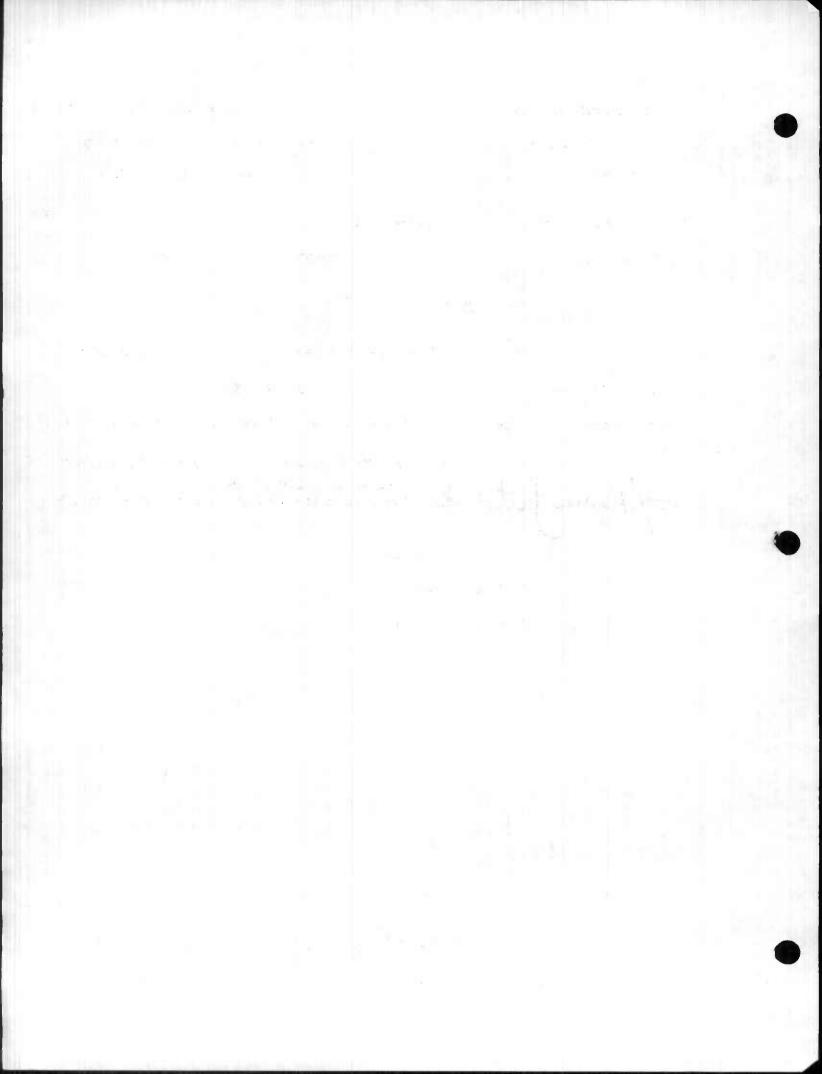
State Registrar

31. Date filed (Month, Day, Year) AUG 1 8 1999

StanLEX Schwartz mo 32. Registrar's Signature

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WISCONSIN AVE

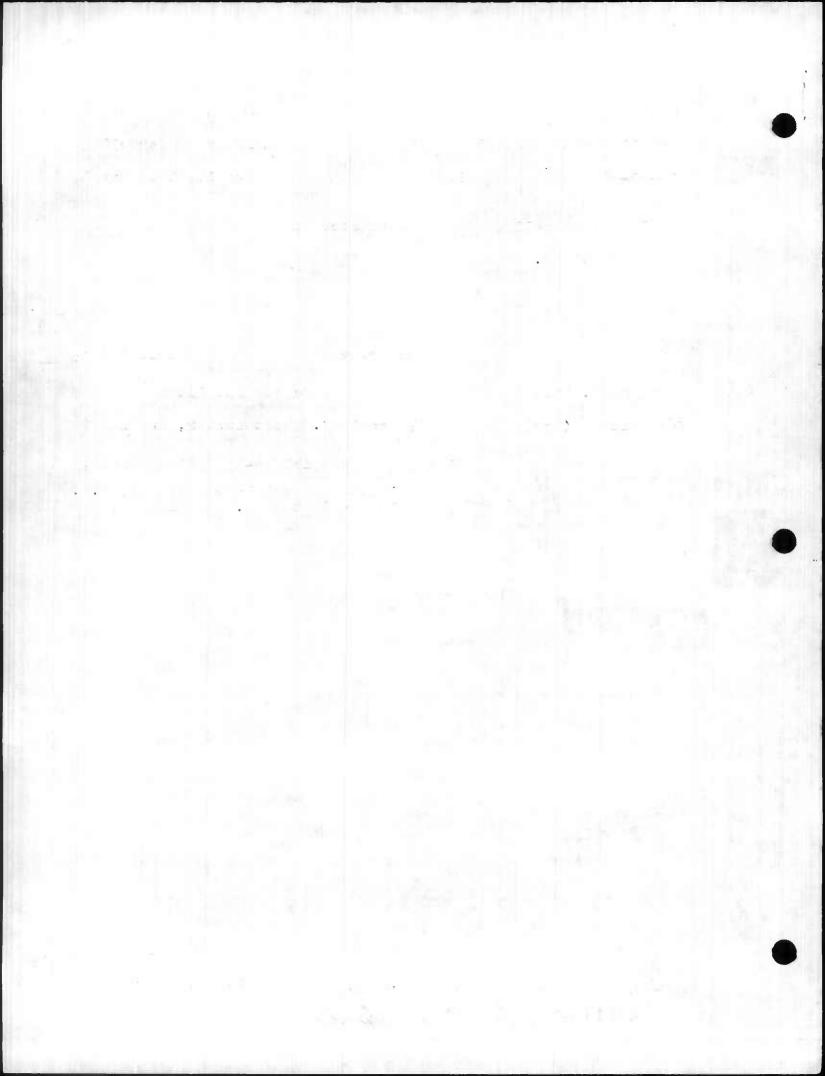


Amended Item #5, 8/20/99 per F.D., Carroll County, cew

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Otato of IVI	arylaria /	Certificate			icinai i iy	Reg. N	5 5) 2	7016
			1. Decedent's Name (First, Middle, Las	1) ~					2. Date of D	eath			3. Time of Death
я	Physici	an	Mills Fld	L. 1)	-: 00				Month		ay 1	Year	6:45 A.
N	/Medic		4a Facility Name (If not institution, give	street and aumber!	100		4h	City, Town, or Lo	cation of Day		c. County	& E &	0. FJ P.L
J.	Examir	er	48 Facility Harrie (II Flot Institution, give	Street end number)			70.	Oxy, Town, or Ex	JOHN OF DOLL		c. County	OI Deatil	
			Carroll County	General	Hospi	tal	Vans I I	Westmi f Under 24 Hrs.			Car	roll	
	Funeral		5. Social Security Number 6. Se 214-01-0194	X 7. Ag DM 2□F	e (In yrs. last b			Hours Min.	8. Dete of Bi (Month, D	rth ay, Yea	r)	9. Birthp	place (State or Foreign htry)
	Director		214-01-0149		90	115.			Apr 15		1909	Mar	ryland
	p a		Usuel Residence of Decedent 10a. Stete 10b. County		10c City Tow	vn or Location		_			-	Τ,	I Od. Inside City Limits
	aho a	-	Tou. Octiny		100. Ony, 100	WIT OF COCATION						- 1	1 ☐ Yes 2 ☐ No
	N I	Director	Maryland Carr	oll	W	estminst	er						I les SEXeo
	5 6	Sire	10e. Street and Number			10f. Zip C	ode			10g. C	itizen of V	Vhat Cour	ntry?
	13 w		307 Crowl Rd	1.		23	158			US	SA		
	72 hours after death with the Maryland natural, or Itema 23a or 28=1 show dical Examinar must be notified at	Funerai	11. Meritel Stetus	12. Wes Decedent	Ever in U,S.	13. Wea Deceder If Yes, specify			ecify Yes or No		14. Raci		an Indian,
0	후 분류	F	1 Never Merried 2 Merried	Armed Forces?		1 - 5 - 1 - 1 - 1 - 1			rucan, etc.)		Blac	k, Whita,	atc.
21215-0020	"natural", or	by	% Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:		1 ☐ Yes 2 €	d No 3	Specify:			Specify	Whi	te
ŏ	72 hours natural',	8	15. Decedent's Edu	ucation	168	. Decedent's Usual (Occupatio	on		16b.	Kind of Bu		
5		Completed	(Specify only highest grad	le completed)		(Give kind of work life. DO NOT use	done dun retired)	ing most of work	ing				
7	within ene. than T	E	Elemantery/Secondery (0-12)	Cotlege (1-4or 5		uck Driv	rer			Chi	emic	97 (Company
	ould be filed within Mental Hygiene. arked other than atic event, the Mental Hygiene.		17. Father's Name (First, Middle, Last)		1 1 1	uch Dir		B. Mother's Name	a (First. Middle	_			ompany
an		Be											
Maryland	2 should and Men is marke surratic	7	Truman G. Pri					Daisey					
Jai	Clare		19e. Informent'a Neme/Relationship (T)			b. Mailing Address (Stata, Zip	Code)
	1 and Health em 27 ither tr	10	Ron Price (So	n)		7 Crowl		West				211	
Baitimore,			20e. Method of Disposition 1 ☑ Burlat 2 ☐ Cremetion 3 ☐ I	Community of Chate	20b. Place o	of Disposition (Name ary, cremetory or other	of er place)		Data	20c.	Location -	City or To	own, Stete
Ē	a hat >		4 Donetion 5 Other (Specify,		Glen	Haven Me	mor	ial B	-16	G1	en B	บากเ	le, MD
aiti	permit. Pa Department Important: any Injury		21. Signature of Funerel Service Licens	:00	MICH	22. Name and				U	011 1	Q Z II Z	
m	Depa Impo any I		A() - 1/ 6	101		Pritts	Fu	neral	Home 8	6 C1	hape	1, F	P.A.
_			23a. Part (Enter the diseese, or comp shock, or heart feilure. List only of	man 3		412 Was	hin	gton R	d. Wes	tm:	inst	er,	MD 21157
			shock, or heart feilure. List only of	ne cause on each li	ne.	not enter the mode of	or aying, :	such es cardiac (or raspiretory e	errest,			Approximete Intervel Between
	Physician												Onset and Death
	/Medical		Immediate Ceuse (Final disease or condition	Sen	1:2								Den.
	Examiner		resulting In death)	8. 3	Due to (or as a	consequence of):						1	·^
_		ner		Dus	nun								John
	ficate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions	b. 1 700		consequence of):							
Ġ.	n an ial-tr	Exe	if english to immediate		10 (0. 00 0	our rought in our ory.							
68760,	sicla bur	100	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	D to for								
289	ifficate g phy as the	edicai	resulting in death) Last		Due to (or as a	consequence of):						- 1	
	ding se a			d									06/
Box	v requires that the death cerifit been signed by the attending I should be detached for use as	lan										1	
	e de	Sic	Pert II. Other algnificant conditions co	ntributing to death b	ut not resulting	in the underlying cau	se given	in Pert I.	23b. Did	tobacc	co use cor	ntribute to	o the cause of death?
P.O.	the base	£							10	Yes	2□ No	3 Pro	bably 4 Unknown
	\$ 500 \$ 500	ò											
5	quire sn si	8							24a. Was			24b. W	era autopsy findings vailable prior to
S	The law requires that sta has been signed by page 2 should be detailed.	Completed by Physician/M							pen	ormed?		60	empletion of cause death?
Re	e la has	Ē									-00		
m	cata	S							10	Yes	2 No	11	Yes 22 No
<u> </u>	iclen: The lav certificata has irector, page 2	Be	25. Wes casa rafarred to medical examinar?	Hospital:				26. Place of Deat	h (Check only	one)			
2	hysi Il din	2	TE Yas 200 No	Hospitel: inpatie	1		Other:	4□ Nursing Ho					fy)
Division of Vital Records,	or Attending Physafter death. Director: After this in by the funeral di	E C	27. Mennar of Death 1 ☑Neturel 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of 280 Injury	. Injury at Work?	t	28d. Describe	how in	jury occur	red	
0	ath. r: A	atic	2 Accident invastigation			М		s 2 No					
Š	American de by ti	E S	3 ☐ Sulcide 6 ☐ Could not be determined	28a. Plece of Injuding, at	ury - At homa, f	arm, street, fectory, o	office		28f. Location . City or To			er or Run	ni Routa Number,
ō	S aft	Certification:		Dunding, att	o. (Openiy)				July 01 10	, wen			
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2		29a. Certifier 1X Certifying Phy	alcian: To the best of	of my knowledg	e, death occurred et	the time,	date and place,	and dua to the	cause	(s) and ma	inner as s	stated.
	Pru Pru	edicai			examination as	nd/or investigation, in							
	ithin o the	2	29b. Signature end title of cartifier			29c. I	icense n	umber		29d. D	ate signe	d (Month.	Day, Year)
	F3F8		1000			Λ	11 -			1		. ^	1.0
			We mat Ill			17)	401	7 77		100	graf	12	-1 1588
			30. Name and addrass of person who co	ompleted cause of d	leath (Item 23a)	(Type, Print) 2	00 M	emori <u>al</u>	Aye.,	West	mins	ter,	MD 21157
			Kuchif Ict	erall in	· 17.	Como	C	Lure	uep	an	1 t	וייטו	plel.
	Sta	te	31. Deta filed (Month, Dey, Year)		ar's Signetura	1. 1		1				/	
	Registr	ar	AUG 1 6 1999	Ane	ve /	G. Spar	Kel						
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				State of Ma	ryland /		artment rtificate			ind Men		ene	9 2	1217
			1. Decedent's Nama (First, Middla, L.	ast)							Data of Death	Dev		3. Tima of Death
	Physici ' /Medic		Clifford All	en PALM	ER, Sr						Month gust 16	Day 5.1999	Year	2:15 p.m
	Examir	_	4a Facility Nama (If not institution, g					4	b. City, Tov	wn, or Location		4c. County	of Death	
4		u	Garrett County M	emorial Hos	pital				0akla			Gar	rett	
	Funeral		Social Sacurity Number 6.		(In yrs. last I		If Under Months	1 Yaar Days	If Undar 2 Hours	24 Hrs. 8.1 Min.	Data of Birth Month, Day, Y	'ear)	9. Birthplace Country)	e (Stata or Foraign
Ы	Director		235-66-2416	1⊠M 2□F	54	Yrs.					y 2, 19			irginia
	pue *		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, To	wn or Lo	cation						10d	Insida City Limits
	daryle f sho	ō						1						1 ☐ Yas 2 ☑ No
	the 1	e c	MD Gar:	rett			aklar 10f. Zip				100	. Citizen of V	What Country	7
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Exervine must be notified at	Funeral Director	1349 Alt House H	ill Road					1550				U.S.A	
	ms 2	era	11. Marital Status	12. Was Decedant Ev	rar In U,S.	13.	Was Deced			gin? (Specify , Puarto Rica	Yas or No-		e - Amarican	Indian,
0	r he		1 Navar Married 2 Married	Armed Forcas?						, Puarto Rica	in, atc.)		ck, Whita, atc.	
020	ali, o	by	3 ☐ Widowed 4 ☐ Divorced	if Yas, Giva Yaar or Datas:			1 Yas 2	X No	Specify:			Specify	Whi	te
5-0	72 ho	Completed	15. Decedant's E (Specify only highast g		16		dent's Usua kind of wor			of working	16	b. Kind of Bu	usinass/indus	try
121	ithin	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us							
2	filed within Hygiene. Ather than somt, the Men.	Co	5th			Coa	al Min	er	40 14 4				Minin	g
and	d out	Be	17. Fathar's Name (First, Middla, Las						18. Mother	r's Name (Fi	rst, Middle, Ma	iden Suman	10)	
7	2 should be filed v and Mental Hygie Is marked other t raumatic event, to	To	Frank	Palmer				(8)	Sarah			Ki		4.1
Ma	12 st h and lis n traun		19a. Informant's Name/Relationship		15						outa Number, (
e,	iges 1 and 2 should be filed within 72 hours after death with the Marylen at of Heelth and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Modical Exprinter must be notified at	ŀ	Loiyresa P. Palme	er/ Wife	20b. Placa		9 Altosition (Nam		ise Hi		oak]		MD 215. City or Town	
00	Pages nent of It ant: If ite ury or of		1 ☐ Burial 2 X Cramation 3				natory or or			1				
Baltimore, Maryland 21215-0020	permit. Pages 1 en Department of Heal Important: if item 2 any Injury or other once.	-	4 Donation 5 Other (Spec		Um		Crema 2. Nama an				20/99 1	lorgan	town,	WV
Ba	Departr Importa any Inju		T M C	TAGO. C	ì	6.2				al Hom	e			
			23a. Part1. Entar tha disaasa, or cor	1 salvaniani	no death D	o not ont	32 S.	Sec	cond S	St., O	akland,	MD 2	1550	proximata
g.	Discolation		shock, or haart failura. List onl	y ona ceusa on aach lina		o not and	ar tra moor	a or ayırı	y, such as t	Cardiac or ra	opiratory arras		. in	tarvat Between
	Physician /Medicai		Immediata Cause (Final						1	D1-			W.	
	Examiner		disaasa or condition rasulting in death)	a. Arterio	oscler			lova	iscula	ar Dis	ease		1.0	ears
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	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions	b	ua to (or as	a consec	uence of):							
o,	an ar	EX	Sequantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury											
8760,	nysici	dicai	Cause (Disaasa or Injury that initiated avants rasulting in death) Last	c	ua to (or as	a conseq	uance of):							
Φ	Se Se	Wed	rasulting in South, Cast											
Вох	that the death certificated by the attending placed for use as t	Physician/Me		d										
0	the death by the atter	SIC	Part ii. Other significant conditions	contributing to death but	not resulting	in tha u	nderlying co	eusa giv	an in Part i.		23b. Did tob	ecco uss co	ntributs to th	e cause of death?
٣.	d by	E	COPD								1 🗆 Yea	2 No	3 Probab	Unknown
ds,	8 5 8	l by				_				-	24a. Was an	- utameu	24h Wers	autopsy findings
Records,	v require been si should	Completed	Daibetes								performe		avalla	bla prior to lation of causa
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											1 🗆 Yas	2 ₩ No	1 D Y	as 2 No
Vital	ysician: The	Be	25. Was cesa refarred to medical axaminar?	Hospital:	- J			Oth			heck only ona)			
ō	5 00	. To	1 ☐ Yas 2 ☒ No 27. Mannar of Death	1 ☐ Inpatian		Outpatier o. Tima of					5 Aasidan			
P	Jing After fune	tion	1 Natural 5 ☐ Pending	(Month, Day	Year)	Injury	м	8c. Injun Work	k? Yas 2⊡t			,,		
S	or Attending after death. Director: After in by the fune	fica	3 Sulcida 6 Could not	ba Rings of Injur	v - At home.	farm, str					Location (Stre		ber or Rural R	oute Number,
Division of	Dire.	Certification:	4 Homicida datarmine	building, atc.	(Spacify)		, , , , , ,	,			City or Town,	Stata)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Cartifiar 1 Certifying P	hysician: To the bast of	my knowled	ge, death	n occurred a	at tha tin	na, data and	d place, and	due to the cau	sa(s) and ma	annar as state	ed.
	n 24 } n 24 } ne Fui	edicai	(Check only 2 Madical Exa	miner: On the basis of e and mannar state	xamination a	and/or in	vastigation,	In my of	pinlon, daat	th occurred a	t the tima, dat	a and place,	and due to th	a ceuse(s)
	within to the comple	M	29b. Signatura and titla of certifiar				290	. Licens	a number		290	d. Data signe	d (Month, Da	y, Year)
			PATINIA	8 my	Qe.	LE	7	1261	54			8/1	7/99	
	1		30. Name and address of person who	completed ceuse of dea	ath (Item 23a	a) (Type,					-	5/1		
	10		Dr Paul D Mill	r	69 WO	1 f A	orac	0a1	heels	MD 2	1550			

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State Registrar

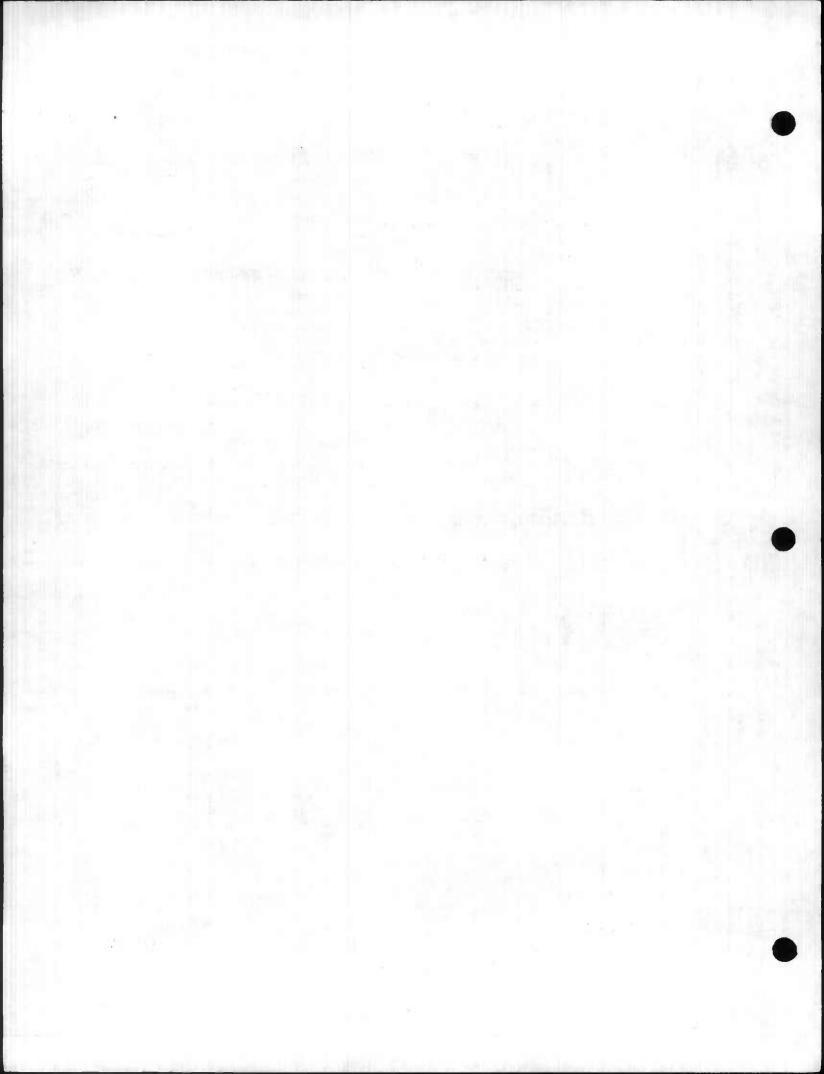
III Silver to a control

_				ate of Maryla		tificate of			giene	27248			
	Physic		Decedent'a Nama (First, Middle, Last) Anne V. Robinson					2. Date of Dea Month AUQUST	_	3. Time of Death Year 99 2;10 P.M.			
		Medical Examiner 4a. Facility Nama (If not institution, give street and number) 4b. C Egle Nursing Home						r Location of Death 4c. County of Death					
T	Funeral Director		5. Social Security Number 214-07-2830 6. Sax 1 □ M		. last birthday) Yrs.	If Under 1 Yaar Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth	3ear)	9. Birthplace (Stata or Foreign			
	Aenylend I show	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. Stata 10b. County Maryland Allegany		ity, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yas 2 □ No			
020	th with the A 23a or 28a-		10e. Street and Number 217 Centenial Street 10f. Zip Code 21532- 10g. Citizen 2 LS.A.							of What Country?			
	filed within 72 hours efter death with the Menyland Hygiene. ther than "natural", or thems 23a or 28a-f show that the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 1 3 Widowed 4 Doivorced 1	li	S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto				- Amaricen Indian, , White, atc. †e				
21215-0020			15. Decedent's Education (Specify only highest grade com Elementery/Secondary (0-12) 0 Company (0-12)	(Give I	ent's Usual Occup kind of work done OO NOT use retire ng Departn	during most of world)	king	16b. Kind of Bus extile manu	Marie School				
Maryland	d 2 should be filed with th and Mental Hygiene. 7 Is marked other than traumatic event, the M		17. Fether's Name (First, Middle, Last) Terrence Woods				18. Mother's Nem		Maiden Sumeme)			
	Tall the		19e. Informant's Name/Relationship (Type, Po John C. Sullivan Aftor	•		g Address (Street Spect Square	end Number or Ru	ral Route Number	r, City or Town, S Marylan				
Baltimore,	of T		20a. Method of Disposition 1 Disposition 3 Remov 4 Donation 5 Other (Specify)	20b. Sair	Place of Dispos cemetary, crem of Michael	sition (Name of latory or other pla S Parish Cerr	ce) netery 16-		20c. Location - C	ity or Town, Stata Aaryland			
Ball	permit. Peg Department Important: It any Injury o		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532										
	Physician /Medical Examiner	J.	23a. Pen Enter the disease, or complication shock, or heart failure. List only one caulimmediate Cause (Finel disease or condition resulting in death)	Cardion Due to (or esta consequ	. \	ng, such as cardiac	or respiratory arm	r respiratory arrest, Approximate Interval Betwee Onset and Deat				
x 68760,	leath certificate be executed attending physician end for use as the bunal-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or Injury thet initiated events resulting in death) Last	ilamec	or as a consequence or as a consequence	enterio	o saase seler oŝi	\$		10 years			
D. Box	it the death certi by the attending tached for use a	Physician/M	Part II. Other significant conditions contributi	ng to death but not res	sulting in the un	derlying cause gi	van in Part I.	23b. Did to	bacco use conti	ribute to the cause of death?			
s, P.O	gned b	Be Completed by Phy			Dementia					1 🗆 Y	•s 20 No	B Probably 4 Unknown	
of Vital Records,	8w 2 s L						24e. Was an autopsy performed? 24b. Were autopsy finding available prior to completion of causa of deeth?						
talF	ate pag		25. Was case referred to medical				26. Place of Deal	1 Ye	/\	1 ☐ Yes 2 ☐ No			
of V	0 0	2	examiner? 1 Yes 2 No Hospite	1 ☐ Inpatient 2 ☐	ER/Outpatient		ner: 4 Nursing Ho	ome 5 Reside		(Specify)			
	ng the	atlon	1 Naturel 5 Pending 2 Accident investigation	. Date of Injury (Month, Dey Year)	yat k? Yas 2 □ No	28d. Describe how injury occurred							
Division	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fr	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined 28s	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)									
	e Hospi 24 hou e Funer detely fill		29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: 0 au	To the best of my kno the basis of examina d manner stated.	owledge, death ation and/or Inve	occurred at the tirestigation, in my c	me, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and mannate and place, an	ner as stated. d dua to the cause(s)			
	withir To th comp		29b. Signature and title of certifier	e number	2	(Month, Day, Year)							
	Es.		30 Name and addison of source	M.AM.	- 02-1 /T		7004		8/15	199			
	6		30. Name and address of person who complete L.R. MILES JR. M.	D. 57 J	ACKSO	N ST.		CONIN	6 MT	> 21539			
	Sta Registra		31. Dete filed (Month, Dey, Yeer) AUG 1 7 1999	32. Registrer's Signa	ature A.	Louis							

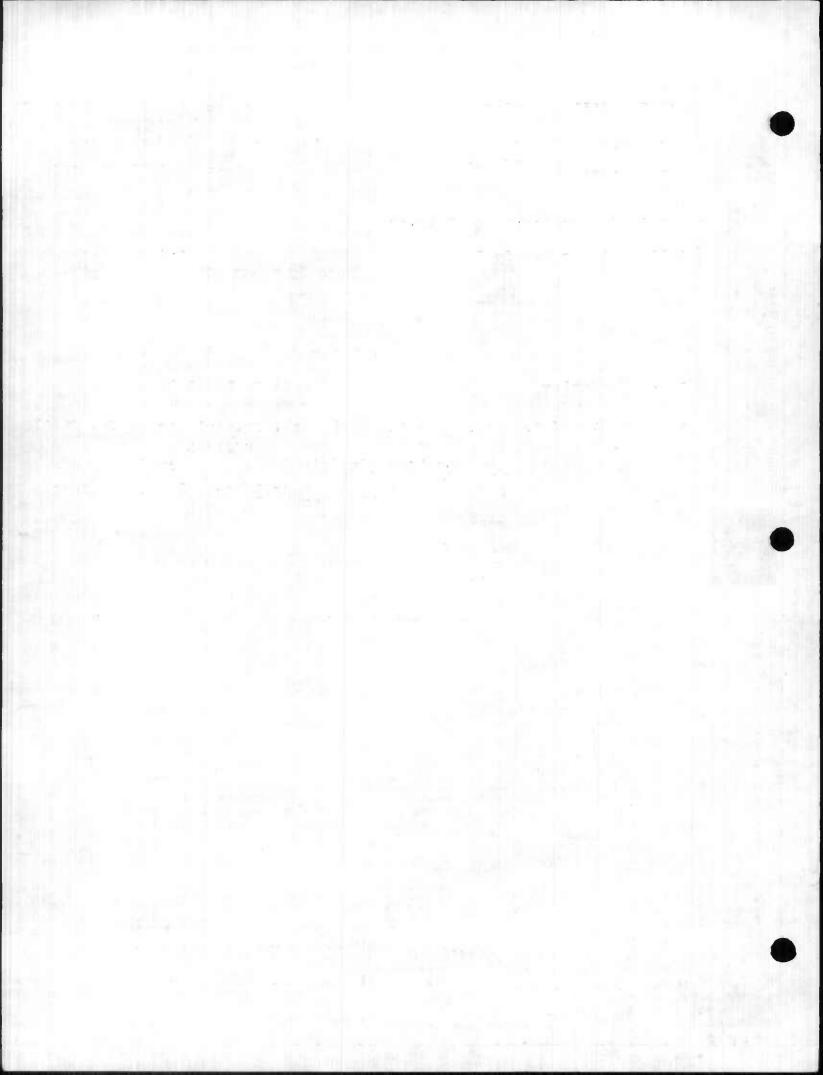
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State of Maryland / Department of Health and Mental Hygiene

December 1 Annual Process Control Process					C	ertificat	e of	Death		Re	g. No.	for for	16	1.0
Exeminer Fairty April Paint P	1111		1. Decedent's Name (First, Middle, La	st)						2. Date of Death	h		3. Time	of Death
Storminer Finding Management and number and number) See 1 Facility Men of mich indication, per water and number) See 2 Facility Men of mich indication of the mich of the m			Иомич	c Robinson									2.20	2 426
\$9.00 A city hours of the control of	10.0					-	- 14	4b. City, To	own, or Lo				13:31) AM
Securit Security Number Se	Exam	miner		STEED STORES										
The first first of a Control of Section 1 (Section 1)				ane 7 Acc //p or	n lant historie	if Under	1 Vear	Bethe	sda 24 Hrs	9 Date of Birth	Mont			Carrier
Singular District Service Control Care Control				ISM 2□F		Months				(Month, Day,		Coun	ntry)	or Foreign
The second of th	Direct	tor		74	170.					Oct. 24,1	924	Illir	nois	
98.08 Ashburton Lane 208.17 USA 11 Mere Balance 12 Was Deposited Four PUS. 13 Was Decodered of Higherton Cologn? (Specify Year or No. 14 Race - American holder. 15 Race - American holder. 16	2 *			100 (City Town or	Location						1	Od Ineida	City Limits
98.08 Ashburton Lane 208.17 USA 11 Mere Balance 12 Was Deposited Four PUS. 13 Was Decodered of Higherton Cologn? (Specify Year or No. 14 Race - American holder. 15 Race - American holder. 16	arya and	- 1												
98.08 Ashburton Lane 208.17 USA 11 Mere Balance 12 Was Deposited Four PUS. 13 Was Decodered of Higherton Cologn? (Specify Year or No. 14 Race - American holder. 15 Race - American holder. 16	2 PH	ctc	Maryland Montgomery Bethesda										1010	2 2 36 140
16. Deceder 1 Schoolson (Specific or Principles and Congretion (Specific or Congretion (Specific	5 5 8	- F	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou									What Coun	ilry?	
16. Deceder 1 Schoolson (Specific or Principles and Congretion (Specific or Congretion (Specific	f) w 23a ant 2	10	9808 Ashburton L	ane			2081	17			USA			
16. Deceder 1 Schoolson (Specific or Principles and Congretion (Specific or Congretion (Specific	dea dea	nec	11. Mentel Stetus	U,S. 1	13. Was Decedent of Hispanic Origin? (Specify Yes or				ecify Yes or No-					
16. Deceder 1 Schoolson (Specific or Principles and Congretion (Specific or Congretion (Specific) à 4g	2	1 ☐ Never Married 2 ☑ Married	1 ⊠Yes 2 □ No	1 ⊠Yes 2 □ No					Pican, etc.)	Black, White, etc.			
16. Deceder 1 Schoolson (Specific or Principles and Congretion (Specific or Congretion (Specific	1	by	3 Widowed 4 Divorced		TT	1∐ Yes	2 No	No Specify:			Specify		te	
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23. Part I. Either the diseases, or complications this frausated the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infancial Element (Interdict Cause (Final disease) or condition resulting in death) Due to (or as a consequence of):	a de de de	ou o	0111	11/1	F	rancis	J.	Co11:	ins l	Funeral I	Home,	Inc.		
Physician (Modical Examiner) Physician (Modical Examiner)			William	of Dyl	5	00 Uni	vers	sity 1	Blvd.	., W., Sil	ver Spi	ring,	MD 20	901
Physician (Modical Examiner) Physician (Modical Examiner)			23a. Part1. Enter the disease, or corr shock, or heart leijure. List only	plicetions that caused the de one cause on each line.	ath. Do not o	enter the mod	e of dyin	g, such as	cerdiac	or respiretory arre	est,	i		
Sequence of conditions Sequence of conditions Due to (or as a consequence of):	Physicia	an											Onset end	d Death
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Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown	and all-tra	X	Sequentially list conditions, if any, leading to immediate	Due to	(or as a cons	sequence of):								
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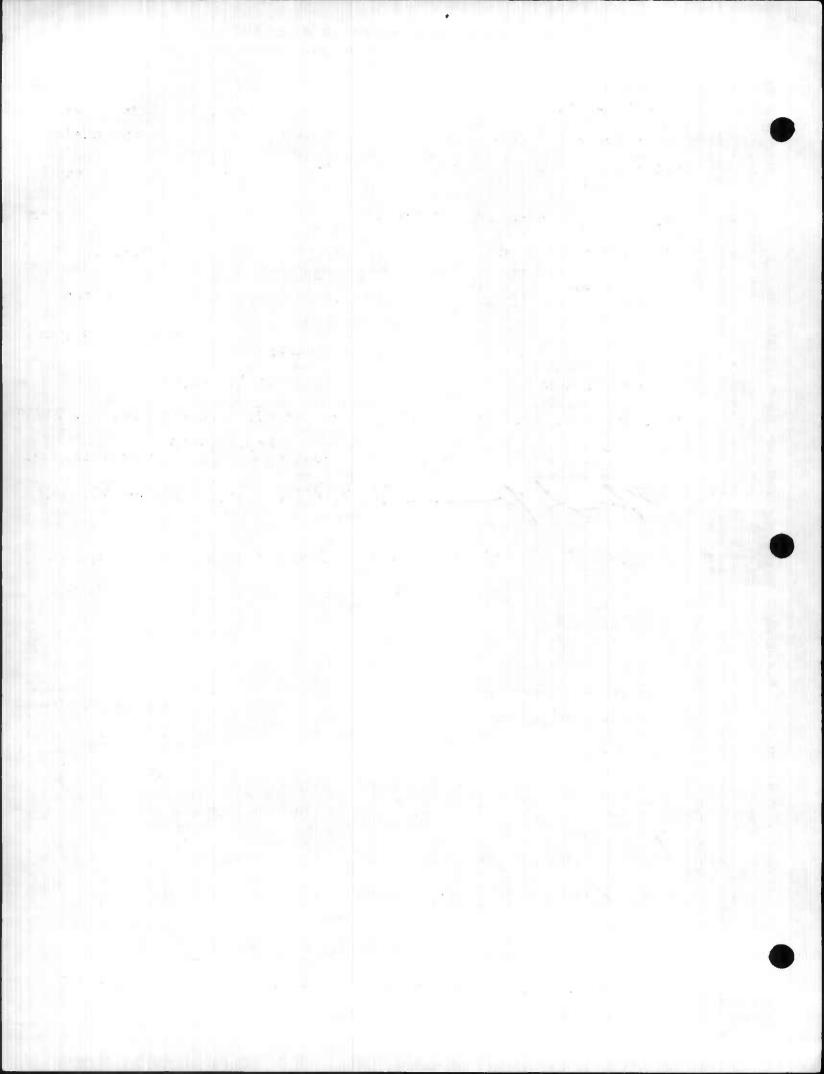
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	Physicia /Medic		HAZEL BELLE	ROWE					August	Day 18, 1		12:20 PM		
	Examin		4a Facility Name (If not institution, gi	ve street and number)				4b. City, Town, or	Location of Death					
			Manor Care Pot	omac				Potoma	0	Mon	tgom	erv		
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last	birthday) If Und	er 1 Yea	r If Under 24 Hrs	S. 8. Date of Birth	h Your	9. Birth	place /State or Foreign		
L	Director		577-34-7971 Usuel Residence of Decedent	1□ M X (XF 8:	7	Yrs.	Day	TIOUS INIE	8. Date of Birth (Month, Day Sept.	25,191	1 Vi	rginia		
	land a		10a. Stele 10b. County		10c. City, T	own or Location					1	Od. Inside City Limits		
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	3a o	Funeral Director	10714 Potomac	Tennis La	ane		201	854		Unite	d St	ates		
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Maryland 21215-0020	n 72 hours after death with the Manylan "netural", or items 23s or 28s-f show Sign Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)			(Give kind of w	6a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business/Industry		
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			23a. Pert1. Enter the disease, or coff shock, or heert feilure. List only	plicellons that shused one ceuse of each lin	the death. (Do not enter the mo	de of dy	ring, such es cardia	c or respiratory an	rest,		Approximete Interval Between		
	Physician		verse unit unit									Onset end Death		
	/Medical Examiner		Immediate Cause (Finel disease or condition resulting In death)	Pneum	onia							l week		
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oʻ.	ificete be executed g physician and as the buriel-transit	ed by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		Due to (or as a consequence of): Cerebrovascular accident 2 weeks) weeks			
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Division of Vital Records,	been signed by should by								24a. Was a	an autopsy		ere autopsy tindings ailable prior to		
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<u> </u>	er de recto by th	Certification:	2 Could not be							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ö	ta saft and		Outoning, etc. (Specify)											
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
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)	-	30. Name and address of person who	completed cause of de						,		,		
				M.D. 49	10 HA	ssachute	s A	12 N.W	- WAshir	yton. I	S.C.	20016		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 0:700 ADRIAN P. REED 16 199 Aug. 1
4b. City, Town, or Location of Deeth /Medical 4a Facility Name (If not Institution, give street and number) Examiner Centreville Queen Anne's 1464 Lands End Road If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1√XM 2□ F 073-32-0507 68 Yrs. **Director** Apr. 26,1931 New York Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Pages 1 and 2 should be filed within 72 hours efter deeth with the Manylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examples must be not lifed. Centreville 1 ☐ Yes 2 ☑ No Director Queen Anne's Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1464 Lands End Road U.S.A. 21617 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry White, Weld & Co. Elementary/Secondary (0-12) College (1-4or 5+) Investment Banker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Permelia Pryor Joseph V. Reed 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1464 Lands End Rd., Centreville, Md. Mrs. Nancy J. Reed (Wife) Aug. 18, 1999 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center Stevensville, Md. 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Mars Examiner Due to (or as a consequence of): Examiner preumorea physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Ses for use as signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No þ 24b. Were autopsy findings available prior to completion of ceuse of death? should I Completed 24a. Wes an autopsy performed? has. is certificate ha 1 ☐ Yes or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 250No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ome 8 Other (Specify)
28d. Describe how injury occurred 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Deeth 28c. Injury at Work? 28b. Time of Certification: Affer 1 Netural 5 Pending investigation daath. 1 Yes 2 No 3 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) An 24 hour. The Funeral Direction of the filled in by 6 4 ☐ Homicide Hospital 29a. Certifies Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as steted. edical within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and piece, and due to the ceuse(s) and manner stated. (Check only 29b. Signature and #lie of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Hoey, M.D.: 2540 Ce 2540 Centreville, Rd., Centreville, Md. 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 9 1999



Physician

/Medical

Examiner

Funeral

Director

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Funeral

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Maryland

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Immediate Cause (Final disease or condition resulting in Seath)

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27. Menger of Beeth

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

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(Check only one)

29b. Signature and Li

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Pages 1 and 2 should be filled within 72 hours after death with it and theath and Mental Hygiena.

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Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1999 PATRICIA ANN SHEFFIELD August 7:40 P.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 13, 1931 5. Social Security Number Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🖾 F 67 234 52 6079 Yrs. Sarah Ann, W. VA. Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No Montgomery Silver Spring 10f. Zio Code 10g. Citizen of Whet Country? 14005 Beechvue Lane 20906 United States 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Psychiatric Aide Supervisor Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Spencer Leonard Clara Thomas 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Fulani Sheffield (Daughter) 14005 Beechvue Lane, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/21/99 Silver Spring, MD. 22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave., N. W., Washington, D.C. 20 Approx ruca Enfer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. interval Between Onset and Death anteny stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last muscle of houset pillary Part II. Other eignificant conditions contributing to death but not rasulting in the underlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yee 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? completion of ceusa of death? 25. Wes cese reterred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28a. Date of tnjury (Month, Day 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be determined 28e. Place of injury - At homa, tarm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and place, end due to the cause(s) and menner stated.

Examiner P.O. Box 68760, Division of Vital Records,

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State Registrar David Magliaro,

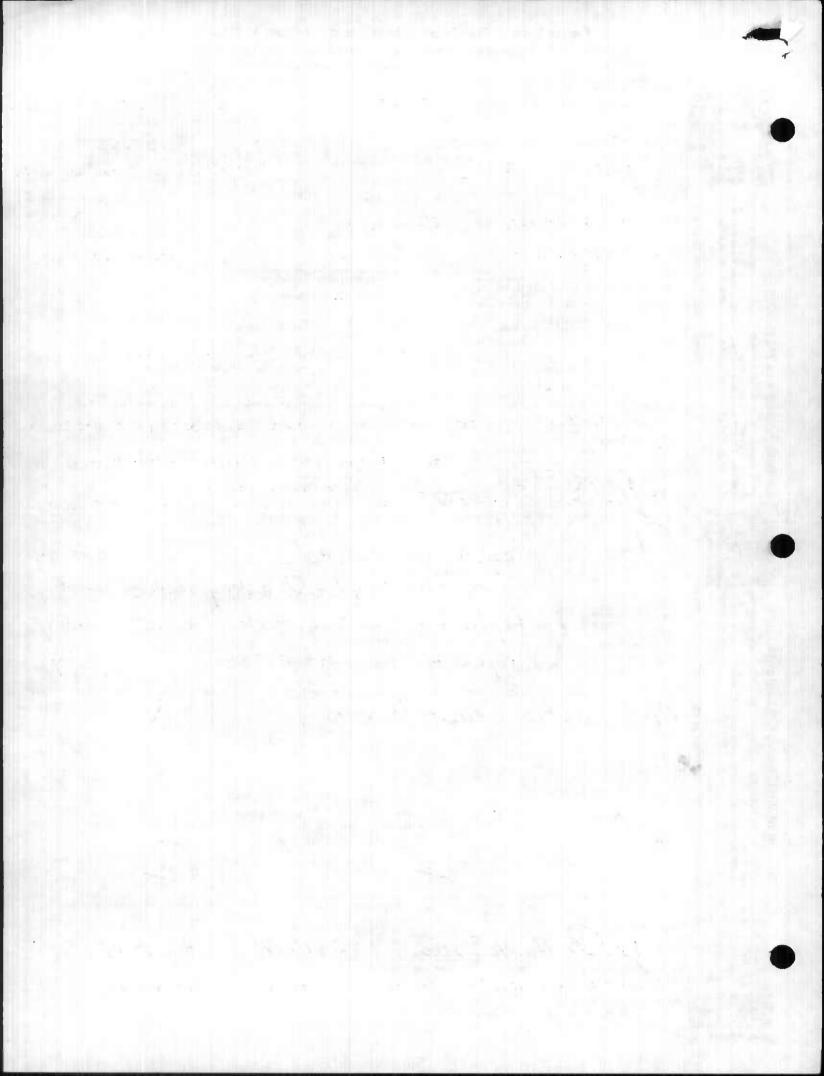
M.D., 18111 Prince Philip Drrive, Olney, Maryland 20832 32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Ms.

29c. License number

29d. Date signed (Month, Day, Year)



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Box 68760. o Division of Vital Records, Attending Physician: death. after deat Director: 8 filled in 24 hours within 24 hor To the Fundamental

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death nev **Physician** Month Veer Robert Rudolph Smith 23 1999 August 2:58 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner VA Maryland Health Care System Perry Point Cecil If Under 1 Yeer If Under 24 Hrs. g. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Deys Months 1**½** M 2□ F Hours 57 Director 238-64-1373 02 - 12 - 42Princeton, NC Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Prince George Hyattsville MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1210 Raydale Rd. 20783 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

1 ★Yes 2 No If Yes, Give 11. Marital Status 14. Rece - American Indien. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced Yeer or Detes: Pe 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementery/Secondery (0-12) College (1-4or 5+) Mechanic 12th Automotive 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 7 is marked of Haywood Smith Retha Mae Whitley 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) or other treur Sarah Foye / sister 1210 Raydale Rd., Hyattsville MD., 20783 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Selma Memorial Garden 8-28-99 Selma NC 21 Signeture of Funeral Servicial Johnson 22. Name end Address of Fecility Sanders Funeral Home,
806 E. Market St., Smithfield NC
Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,
or heart feiture. List only one cause on each line. 27577 Approximete Intervel Between Onsel end Deeth immediate Ceuse (Final Renal Failure unknown diseese or condition resulting in death) Due to (or es a consequence of): Examiner Hypertension unknown Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yas 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease à 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medicei 26. Plece of Deeth (Check only one) Other: 4 XNursing Home 5 ☐ Residence 8 ☐ Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 XNatural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 157 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated.

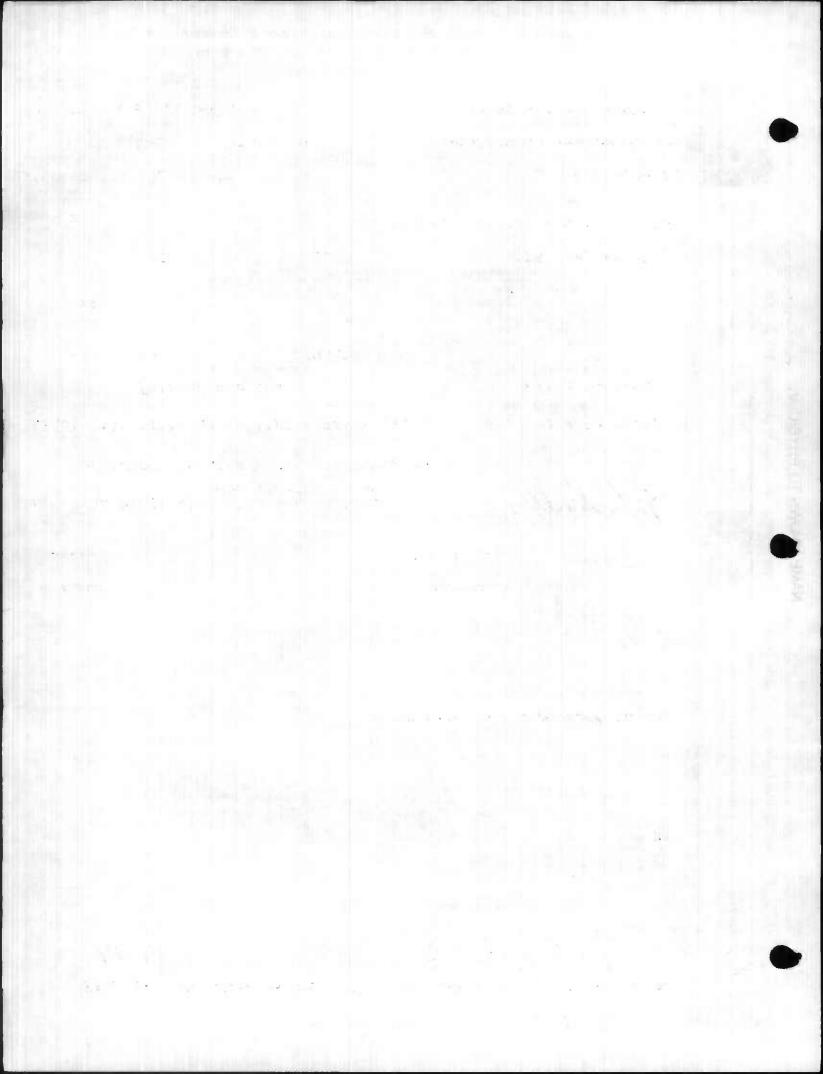
21 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29b. Signeture end titie of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D51778 al 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Jodi B. Segal, M.D. VA Maryland Health Care System, Perry Point, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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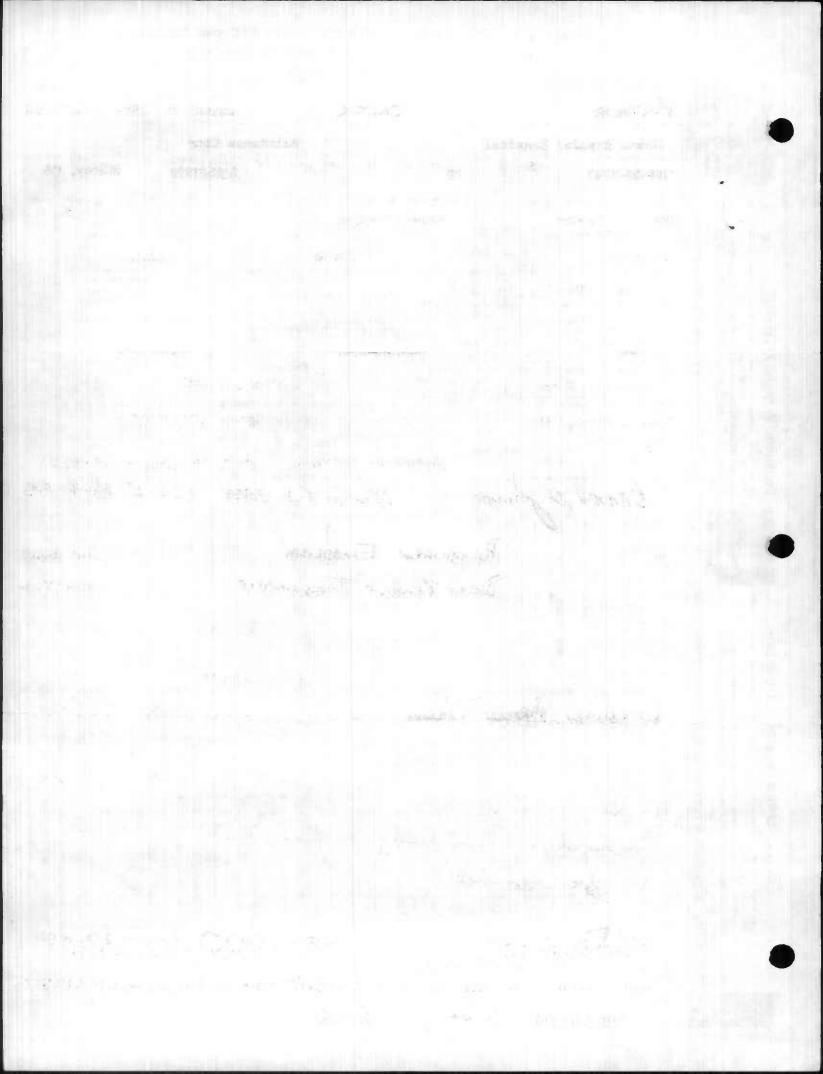
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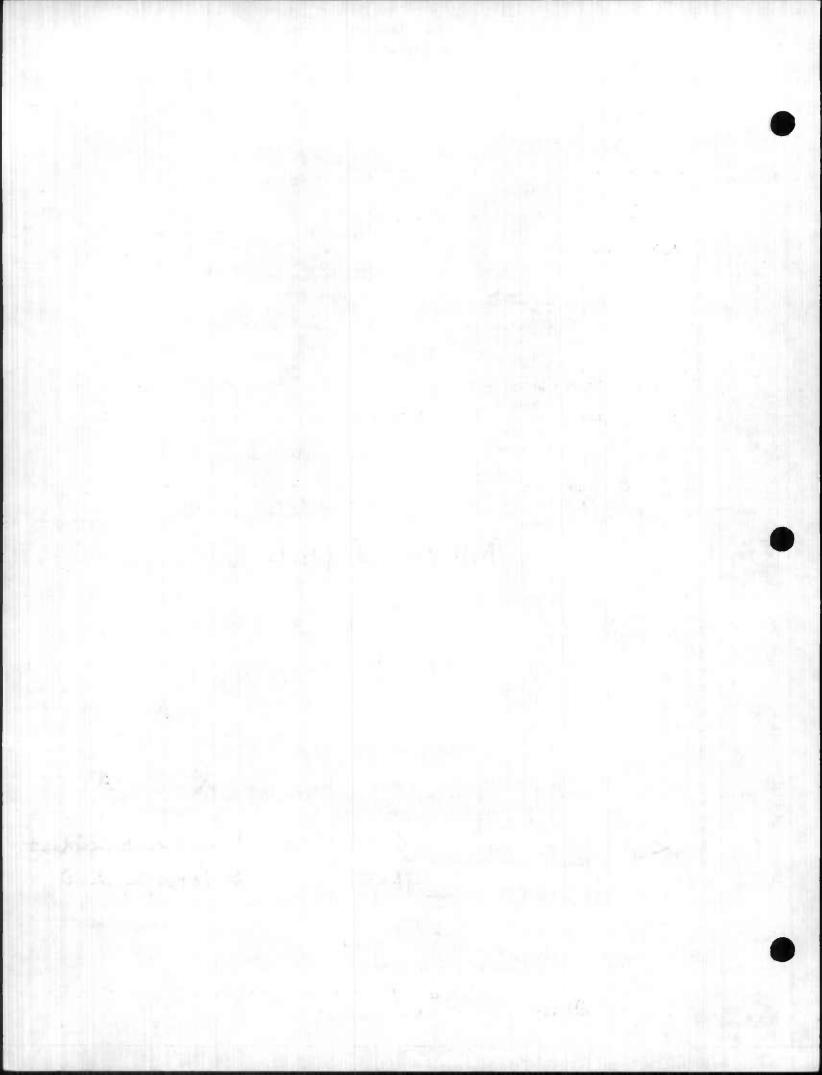
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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. Social Security Number 6.		. last birthday) Yrs.	If Under 1 Yea Months Deys			te of Birth lonth, Day, Ye e 12,		9. Birtho	place (State or Foreign of land
e Maryland Sa-f ahow filled at	10a. State 10b. County		ity, Town or Lo Wald						1	0d. Inside City Limits 1 Tyes 2 No
ith with th	Maryland Charl 10e. Street and Number 4630 Harwich Dri	ve		10f. Zip Code 20	601	U.S.A.				ntry?
15-0020 72 hours after death with the Manyland *natural; or forms 23s or 28s-f show scient Examiner must be notified at	11. Meritel Stetus 1 X Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ※ No			es or No- etc.)	Blad	ce - Americ ck, White, y: Whi	
215-0 nin 72 ho n *natur	(Specify only highest gr Elementery/Secondary (0-12)	ade completed)	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)					b. Kind of B	usiness/in	dustry
be filed within tital Hygiene. d other than event, me the	Elementery/Secondery (0-12) 10 17. Father's Name (First, Middle, Las	College (1-4or 5+)	Cas	hier	18. Mothe	er's Neme (Firs		ood S		ce
arylan should be and Mental marked o	George Lionel			Joann Marie Gonzales						
NOTE, Maryla	19a. Informant's Name/Reletionship Joann M. Sharp/M	other	4630	Harwich						0601
Baltimore, Maryland 21215-0020 Fermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or eny injury or other traumatic event, the Next Franch price.	20a. Method of Disposition 1 M Buriel 2 Cremation 3 C 4 Donation 5 Other (Speci	30	inity N	psition (Name of metory or other pl Memorial	Garde		-1999		-	
mew separate and and and and and and and and and and	21. Signature of typeral Service Light	SLEY MO1164	22	The Hun P. O. Bo					d 206	504
Physician /Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	· Motta	to as a consec	Ing	ving, such es	e cardiac or resp	eratory arrest,		1	Approximate Interval Between Onset and Death
Box 68760, leath certificate be executed attending physician and dror use as the burial-transit	Cause (Disease or Injury that initiated events resulting in death) Last	c	or es a consec							
P.O. hat the do by the detache		1. 4	23b. Did tobacco use contribute to the cause of de							
aw requir						2	4a. Was an a performed		av	era autopsy findings ailable prior to mpletion of cause death?
- F aa (26 Place	e of Deeth (Che	Yes yok one)	2 🗆 No	2	Yes 2□ No
Of Vita Physicien: this certific ral director.	axaminer? 1 ☑ Yes 2 ☐ No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	ther _	ursing Home		a 6 1 0th	ner /Snecii	W COUNTR
ision o thending Ph death. stor: After th / the luneral		28a. Dete of Injury (Month, Dey Year)	28b. Time o Injury	f 28c. Inj W 1[ury al ork? ☐ Yes 2007	No 28f. L	Describe how	injury occur	to a	SCENE CCLO A al Route Number,
Ospital or A hours after uneral Directly filled in by		ysicien: To the best of my kn	owledge, deet			nd place, end du	7 Per	es d		
To the Hospital within 24 hours To the Funeral completely filled	29b Squayure and title of certifier	Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurrence and menner stated. 29b Squarure and title of certifier 29c. License number								Day, Year)
	Can to	leon	= 02e) T	0CI	Æ			AUGUS'	T 16,	1999
	30 Name and address of person who	remp	111 I	Print) Penn Str	et, B	altimor	e. Mar	v]and	-2120)1
State Registrar	7111: 2 11 1	32. Registrar's Sign	ature	Loon						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1999 Julia Anne Montaque Bennett Stamper August 5:30 AM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 202 C Fox Hall Drive Bel Air Harford If Undar 24 Hrs 8. Date of Birth (Month, Dey, Year) Nov. 22, 1960 Maryland 5. Social Sacurity Number Birthplaca (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours Min 1 □ M 25 F 216-80-7961 38 Yrs. **Director** Usuel Residence of Decedent the Maryland 10e Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show agical Examiner must be notified at Harford 1 Yas 2 □ No Maryland Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be liled within 72 hours after death with t. Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and hyllury or other freumatic avent, the Medical Examinet must be posse. 202 C Fox Hall Drive 21015 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yes, Give X Yeer or Detes: Wes Dacedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Maritel Stetus Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) College (1-4or 5+) Elementery/Secondary (0-12) Registered Nurse Health Care 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Ronayne Waldron Bennett Rachel Read Holmes 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 202 C Fox Hall Drive, Bel Air, MD Rachel H. Cruzan/Mother 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 XBurlal 2 Cramation 3 Removel from State Holy Trinity Episcopal 4 □ Donetion 5 □ Other (Specify) 8/14/99 Churchville, MD 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Applied the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Applied to the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Applied to the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Applied to the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 23a. Pert1. Enter the diseese, or complete shock, or heert feilure. List only one Approximate Interval Batween Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) 10 MONTHS METASTATIC BREAST CANCER /Medical Examiner Due to (or as a consequence of):

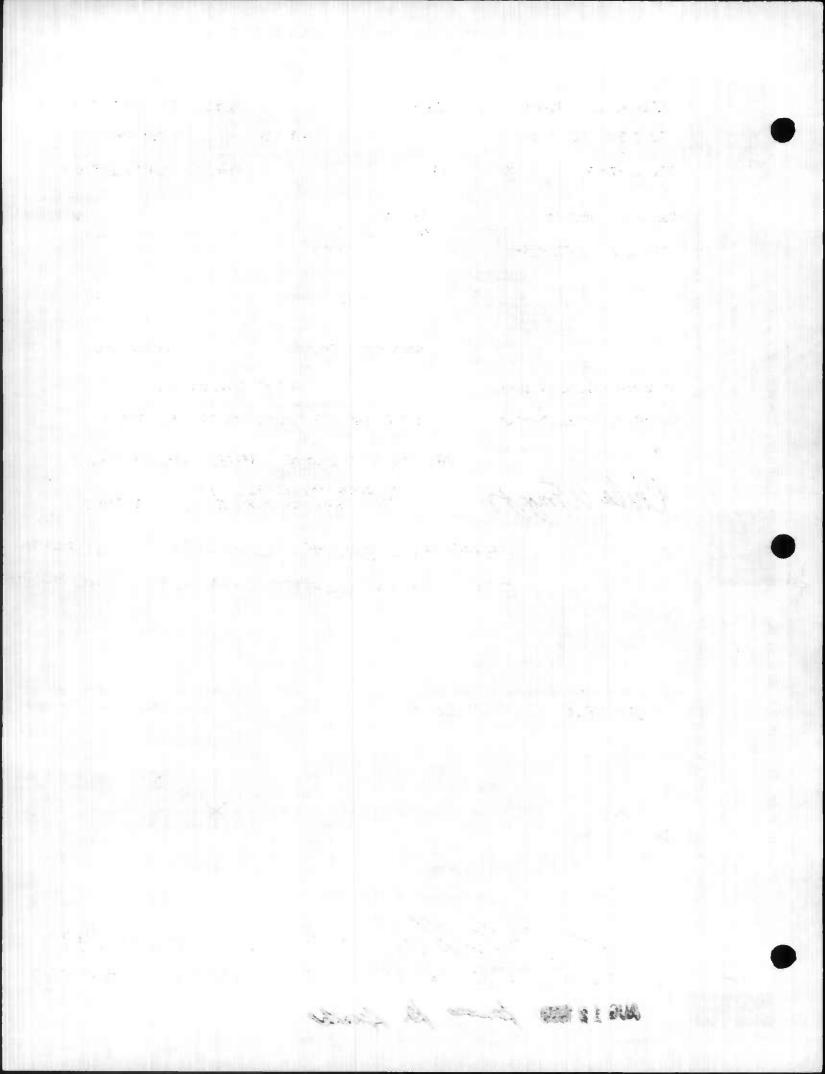
CARLY STAGE BREAST CANCER 40 MONTH Examiner physician and the buriel-transit law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): attending p for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CIRRHOSIS þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? s cartificata has b director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No for Attending Physician: siter death. Director: After this cartifica director, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 1 Yes 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide n 24 hours after Funerel Dire-pletely filled in b Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) To the To the To the 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) JOHNS HOPKINS ONC. CTR

Registrar

31. Dete filed (Month, Day, Year)

32 Registrar's Sign



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 15 scust 11,1999 ZENWIZEUS SHIRE /Medical 4a Facility Name (If not institution, give street and number) Town, or Location of Death Examiner HOSP ITPL BALTIMORE CITY ZOHNS HOPKINS 7. Age (In yrs. last birthday) If Under Months II. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2X)F 438-43-3138 18 MD Director 11/03/1980 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD notifie Cecil Conowingo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23e or 25 Highview Road Funeral 21918 USA Nems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Biack, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married à Baitimore, Maryland 21215-0020 1 Yes 2 XNo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12th Student College 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental He sort: If them 27 is marked oth lary or other traumatic even 88 Donald R. Shirey Robyn Lynn Baird 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott A. Seybrecht 25 Highview Road, Conowingo, MD 21918 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 8/18/99 West Chester, PA 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a. Platt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, allow, or heart failure. List only one cause on each line. Approximete Intervai Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition reaulting in death) TERROSPLANT REJECTION MONTHS Examiner Due to (or as a consequence of) Examiner MONTHS JAZUART EC The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pue Due to (or as a consequence of) Box 68760. FIBROS Physician/Medical the Due to (or as e consequence of) use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 200 No 3 Probably 4 Unknown of Vital Records, Completed by ste has been signated bage 2 should b 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? After this certificate has 2 No 1 ☐ Yes No ours after death.

eral Director: After this certifica
filled in by the funeral director, p Physician: Medical Certification: To Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitei: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)
AUG 1 7 1990

JUNE

32. Registrar's Signature

MORRISON

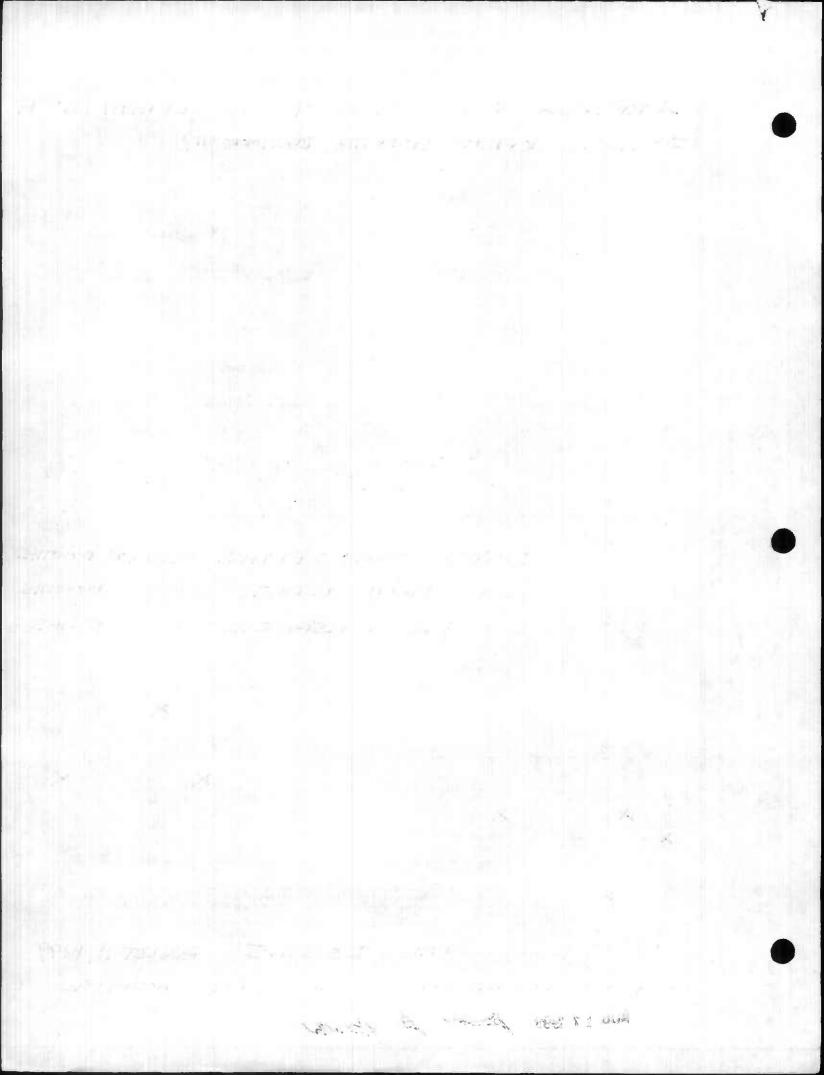
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A Sporth

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JOHNS HOPKING HOSPITE

Bull



5	tate of Maryland	/ Department	of Health	and	Mental	Hygiene

ble.	7258
	3. Time of Death
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of Deat	h
TGO	MERY
9. Birt Co Mis	hplace (State or Foreign unity) SOUTÍ
	10d. Inside City Limits
	1 ☐ Yes 2 ☒ No
What Co	untry?
Stat	es

Physician /Medical Examiner

Director

Funeral

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Completed

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Funeral Director

the Marylend

is 1 and 2 should be filed within 72 hours after death with the Marylen of Health and Mental hygiene.
The man 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic avent, the Marical Experient must be notified as permit. Pages 1 end 2 sh Department of Health end Important: if Item 27 is in any injury or other traum page.

Physician

/Medical

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Baltimore, Maryland 21215-0020

Examiner attending physician and for use as the buriel-transit certificate be executed

Box 68760.

P.0.

Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours effer deeth. To the Funeral Director: After this certific 30

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death August 15, 19 James A. Sisler 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year, January 22, 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 15 M 2 F 562-36-1071 75 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of 9400 Brink Road 20882 United 12. Was Decedent Ever in U,S. Armed Forces? 1 型 Yas 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) U.S. Government Physical Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Neme (First, Middle, Last) Russell A. Sisler Eleanore Rausch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9400 Brink Road, Gaithersburg, Maryland 20882 Mary Sisler/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Dexter Cemetery Aug. 19, 1999 Dexter, Missouri 21. Signature of Funeral Servine 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

The disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest.

Approximately runeral Rockville, Full Programment Rockville, Avenue, Rockville, Maryland 20850-2805

Approximately runeral Rockville, Full Programment Rockville, Full Approximate Interval Between Onset and Death Myocardial Infarction

Due to (or es a consequence of): Immediate Cause (Final 1 hour disease or condition resulting in deeth) Nisease Coronary artery / years Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Part II. Other staniftcant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 No

26. Place of Death (Check only one)

1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Naturel

2 Accident

3 Suicida

5 Pending investigation

1 🗌 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of cartifier Holde MD

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

A Holden David 31. Data filed (Month, Day, Year)

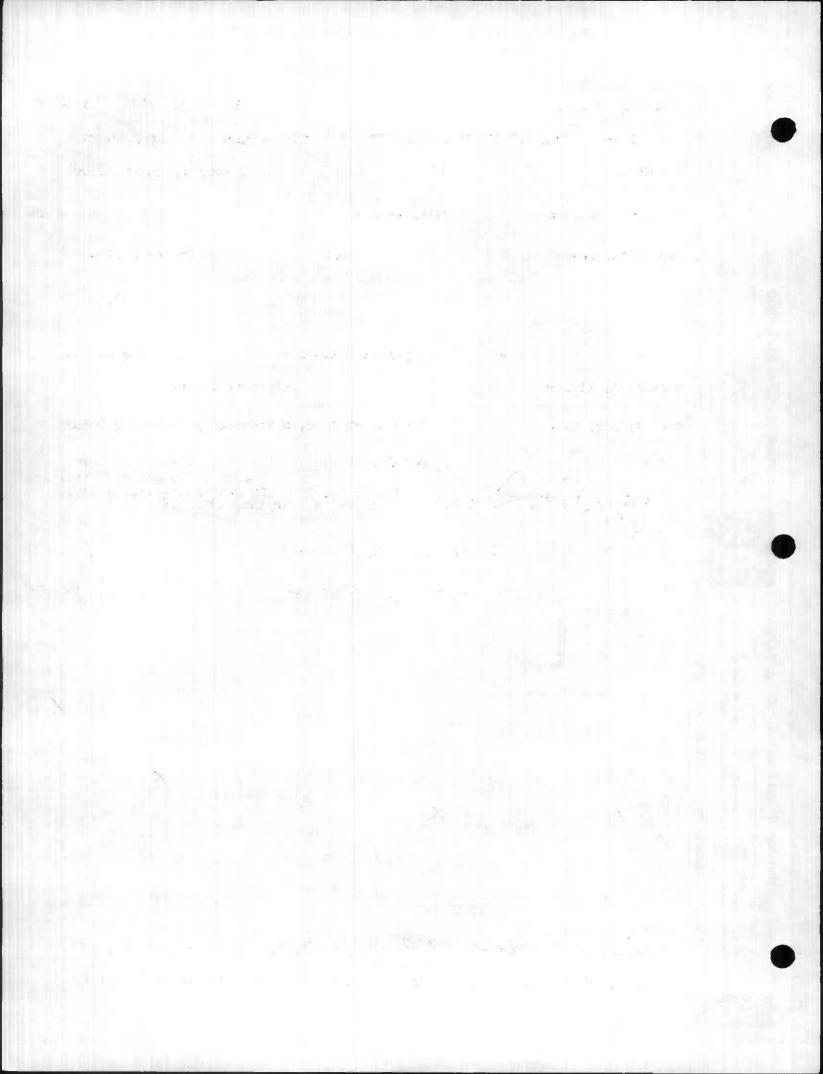
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809 Veirs 32. Registrar's Signature Sereva

mill Rodeville, mo 20851 souls

State Registrar



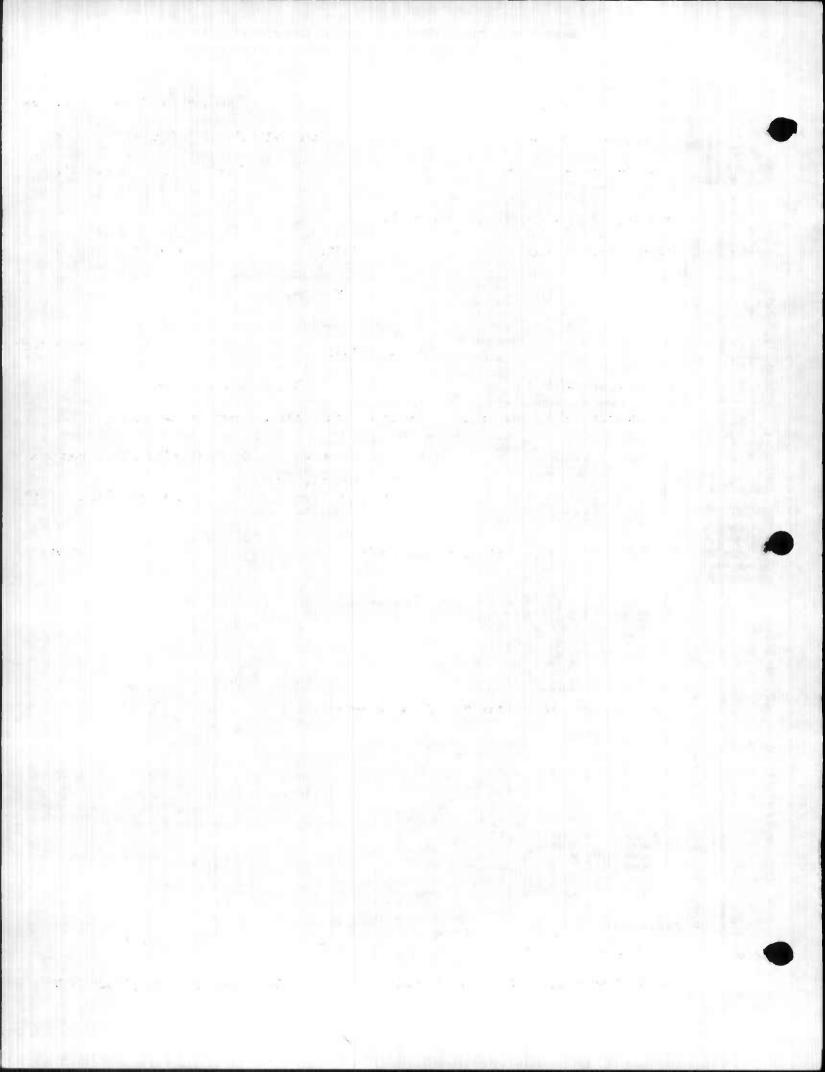
State of Maryland / Department of Health and Mental Hygiene 99

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	/Medica	al .		ith						_			Augus		1999	10:15 AM	
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	Funeral Director		5. Social Sacurity Number 525-54-7255	5. Sax 1□ M	2 ∏ F	7. Aga	(In yrs. last	t birthday) Yrs.	If Under 1 Months	Yea Days		24 Hrs. Min.	8. Data of Bi (Month, Da May 20	th y, Year) , 1916	9. Bir Te:	thplaca (Stata or Foreig buntry) Kas	
	pur	-	Usual Rasidence of Decedant 10a. Stata 10b. County				10c. City, T	Town or Lo	ocation							10d. insida City Limit	
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	1 2 × 1	Pire	10e. Street and Number	_	_		10f. Zip Coda								0g. Citizen of What Country?		
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Σ	nd 2 27 is		Jess Joseph Smit	h		(son)	14518 Church Street, Upper Marlboro				, MD	20772				
Pa Pa Pa	Pages 1 end ent of Health nt: If Item 27 ry or other u		20a. Method of Disposition 1 Burlal 2 ØCramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify)					atery, cres		on (Nama of provider place) Crematory Data 20c. Location - City or To Beltsville,							
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	Physician /Medical Examiner	Jei	23a. PartT. Enter the disease, or c shock, or heart failure. List of immediate Causa (Final disease or condition resulting in death)	nly one c	ause on	aech line	ion Products to the state of th	neumo	nia	of dy	ring, such as	cardiac	or raspiratory a	irrast,		Approximate Interval Batween Onset and Deeth 3 hours	
ς 68760,	g physicie	n/Medical Examiner	Saquentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in daeth) Last	b			Oua to (or as										
Box		an		0													
P.O.	requires thet the deeth	P. P.	Part II. Other significant condition Hypertension, A								rivan in Part I	I.		tobacco uee Yes 2⊠N		to the cause of death robably 4 Unkno	
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ita	certificate		25. Was casa refarred to medical								26. Place	a of Deat	th (Check only	ona)			
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ion o	tending Ph leath. lor: After th the funeral		27. Mannar of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accidant investiga		8a. Data (Mo	a of Injun nth, Day		3b. Tima o Injury	f 28		uryat ork? ⊒Yas 2 🗖	No	28d. Dascribe	how injury oc	curred		
Division	of or Attending of the death. Director: Aft of in by the further of the further	Certification:	3 Suicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rura City or Town, Stata)									lural Routa Number,					
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		Me	29b. Signature end title of certilier		29c. Licensa number					oned (Mon	th, Day, Year)						
	12		Mulde	V						250	079			8/			
			30. Nama and addrass of person w														
			Don H. Yablonow	itz,	M.I)., 7	7404 E	Execu	tive P	1a	ce, #5	502,	Seabro	ok, Ma	rylan	d 20706	

DHMH 16 Rev 6/95

State Registrar 31. Data filad (Month, Day, Year) AUG 19 1999 32. Registrar's Signatura



Months

10f. Zip Code

Computer Engineer

20706

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 2. Date of Death August 14, 1999 ear

If Undar 1 Yaar | If Under 24 Hrs.

Hours

Days

Physician /Medical Examiner

Craig William Stiehler 4a Facility Nama (If not institution, give street and number) 9312 Dubarry Avenue

1. Decedent's Name (First, Middle, Last)

4b. City. Town, or Location of Death Seabrook

Min

4c. County of Death Prince George's

1:10 AM

9. Birthplace (State or Foreign

Funeral Director

the Maryland

with

r than "natural", or flama 23a or 28a-f ahow the Medical Examiner must be notified at Directo Funeral 2 should be filed within 72 hours after death and Mental Hygiena. by Completed

Be

Examiner

Physician/Medical

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Completed

Be

To

Certification:

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ia marked

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any injury or other traum

Physician /Medical

Examiner

attanding physician and for usa as the burial-transit

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Aftar

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To the Hospital o within 24 hours at To the Funeral Di

funeral

omplataly

that the death certificate be axecuted

law requires

Attending Physician:

Box 68760.

P.O.

Division of Vital Records,

5. Social Security Number 1₽M 2□ F 219-48-5429 Usual Residence of Deceden 10a. State 10b. County

Maryland | Prince George's

10c. City, Town or Location Seabrook

Yrs.

7. Aga (In yrs. last birthday)

49

8. Date of Birth (Month, Day, Year) March 4, 1950 Washington, DC 10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Counfry?

United States

16b. Kind of Business/Industry

10e. Sfreet and Number 9312 Dubarry Avenue

11 Marital Status

12. Was Decedent Ever In U,S. Armed Forces?

College (1-4or 5+)

Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.)

14 Race - American Indian Bleck, White, etc. Specify: White

1 □ Navar Married 2 □ Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed)

1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

1 Yas 2 No Specify:

Computer Repair/Service

17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

William George Stiehler

Aldara Dawn Lester

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

Kenneth M. Ricks

19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) 9308 Dubarry Avenue, Seabrook, Maryland 20706

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify)

Chesapeake Crematory

20b. Place of Disposition (Name of cemetery, crematory or other place)

8-14-99 Beltsville, Maryland

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licenses

rol 933 Gist Avenue, Silver Spring, Maryland

22. Name and Address of Facility Rapp Funeral Services, P.A.

Approximate Interval Between Onsat and Death

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardlac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disaasa or condition resulting in death)

Amyloidosis

Due to (or as e consequence of):

Bone Cancer

Due to (or es a consequence of)

Due to (or as a consequence of):

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of deeth? 1 Yss 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings available prior to complation of cause of deeth?

1 ☐ Yes 2 No

1 ☐ Yes 2 1 No

25. Wes case referred to medicel examiner? 1 Yes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Tima of

28c. Injury at Work?

Other: 4 Nursing Home 5 \$\overline{\text{M}} \text{ Residence} 8 Other (Specify) 28d. Describe how Injury occurred

1 Yes 2 No Location (Street and Number or Rural Routa Number, City or Town, State)

26. Piece of Deeth (Check only one)

29a. Certifier (Check only one)

27. Manner of Deeth

1 Netural

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated.

29b. Signature and fifle of certifier

29d. Dafa signed (Month, Day, Year)

5 ☐ Pending

Investigation 6 Could not be

29c. License number 045365

August 14, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

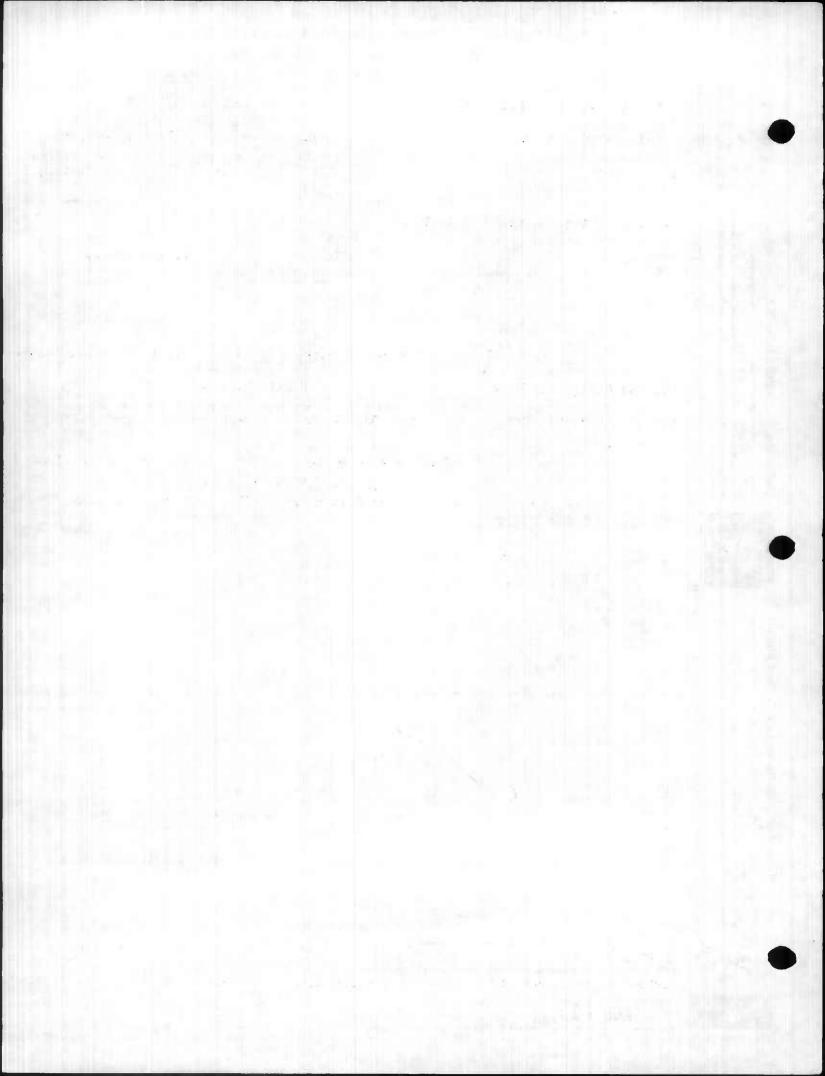
Michael G. Sidarous, M.D., 11701 Livingston Road, #101, Fort Washington, MD

State Registrar

31. Date filed (Month, Day, Year) AUG 16 1999

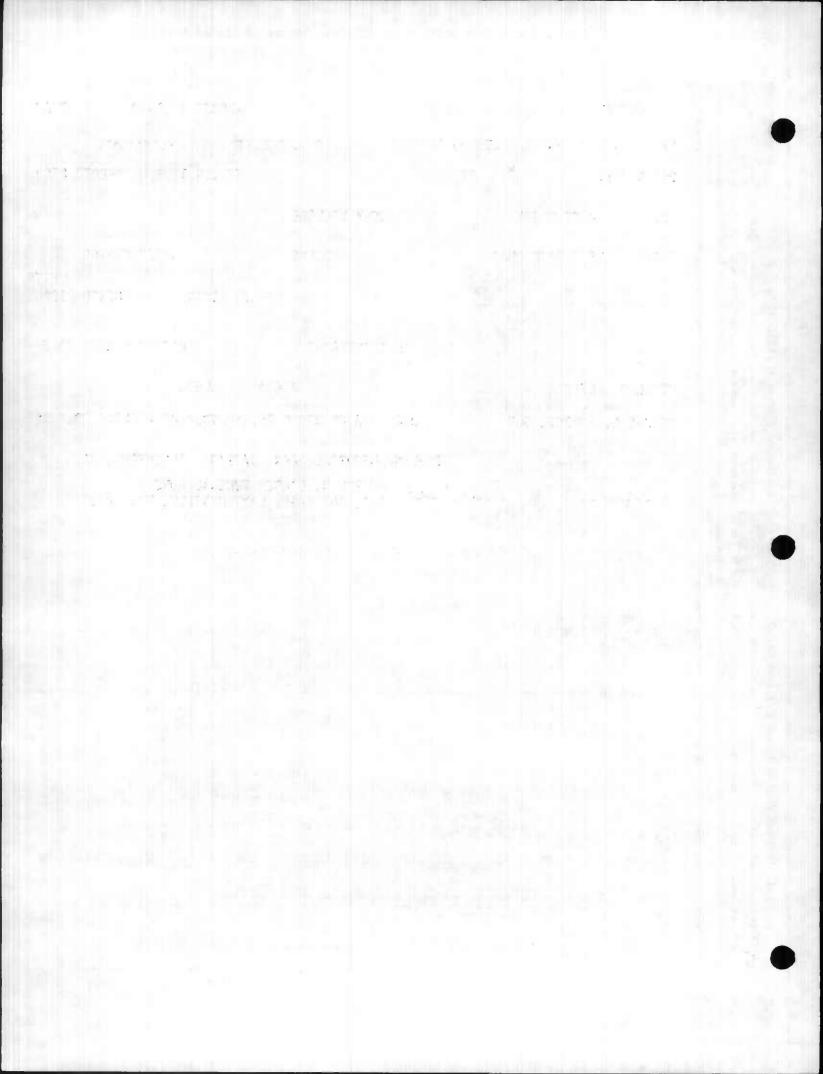
32. Registrar's Signature

Sports



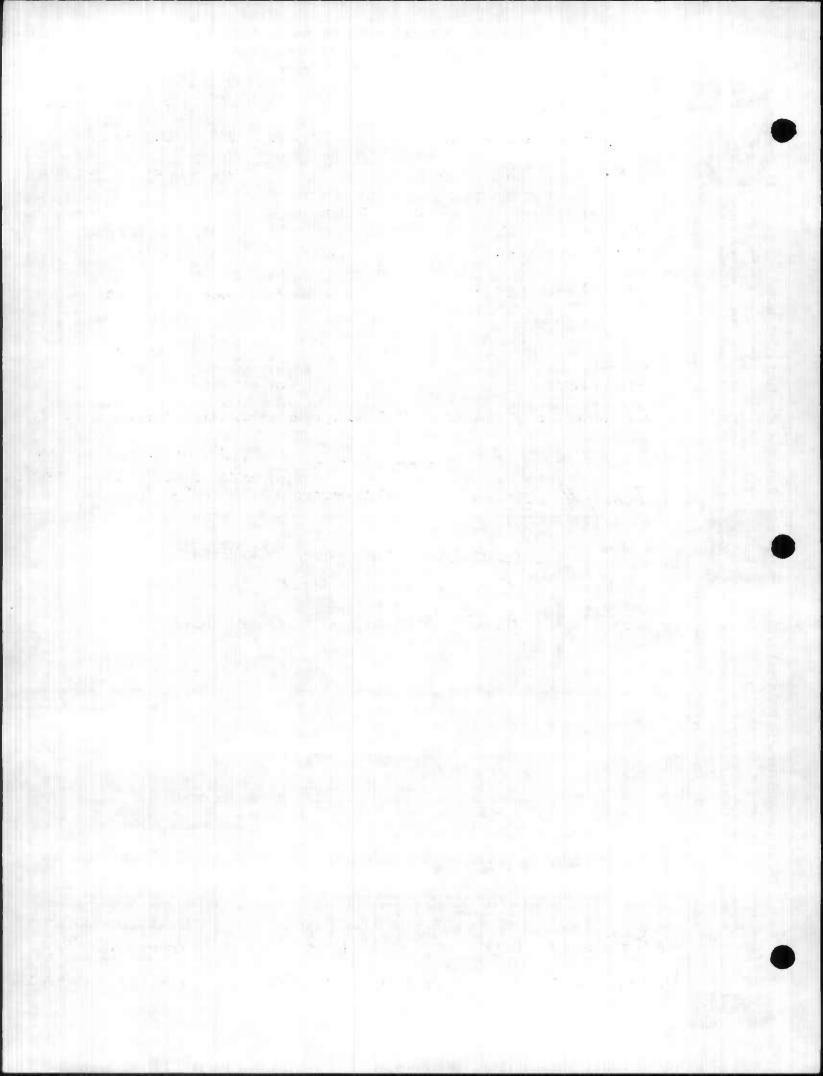
State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate	of Death		Reg. No.				
Physician	Decedent's Nama (First, Middle, Last)					2. Data of Dea Month	ath Day	Year 3. T	ma of Death		
/Medical	ESTHER		SUAREZ			AUGUST	18,1999		57 AM		
Examiner	4a Facility Name (If not institution, giva	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death			
105 20	SHADY GROVE ADV			W11 1 4 1	ROCKVII			OMERY			
Funeral	5. Social Security Number 6. Ser	IM 25F	yrs. last birthday) Yrs.	If Under 1 Y Months D	aar If Undar 24 Hrs ays Hours Min	(Month, De)	v, Year)	9. Birthplace (5 Country)	Steta or Foreign		
Director	084 30 9610	77	YIS.			FEB.18	,1922	PUERTO	RICO		
pu * -	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Ins	Ide City Limits		
Aaryl sho	MD. MONTGOM	ERY	MONTGO	MERY V	ILLAGE			10	Yes 2 No		
vith the Mar or 28=4 si be notified Director	10e. Street and Number			10f. Zip Co	de	10g. Citizen of What Country?					
death with the Maryland me 23a or 28a-1 show rman be notified at neral Director	19116 MILLS CHOIC	F DUVD			20886			STATES			
na 23		12. Was Decedent Evar						- American Ind	an		
urs after al., or its branch by Fui	1 ☐ Never Marriad 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorcad	Armed Forcas? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☑ Yes 2 ☐ No Specify PUF					PUERTO	WHITE		
ed within 72 hours ygiene. er then "neturel", it, tre Medical Ex-	15. Decedent's Edu (Specify only highest gred	cetion	16a. Deced	edent's Usual Occupation a kind of work done during most of working 16b. Kind of Business/Industry							
within a	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	MINISTRATOR HOSPITAL HOME CARE							
filed with Hygiena. rither than ent, m	12	1	AUM	1N121K					CARE		
should be filed within and Mental Hygiena. marked other than imatic event, the Manatic avent, the Manatic a	17. Father's Neme (First, Middle, Last)					me (First, Middle,		e)			
should be and Mental marked or umatic eve	NICOLAS RIVERA				JUANA	DeLE	ON				
s 1 and 2 should be filed within 72 hc thealth and Mentel Hygiens. Item 27 is marked other than "natur other treumatic event, the Middlest To Be Completed	19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Co. 20644 BEAVER RIDGE RD., MONTGOMERY VILLAGE, M										
Health Health lem 27 I	GEORGE L. SUAREZ,										
or off	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖼 R		Ob. Place of Dispo cemetary, crem	netory or othe	r plece)	Date	20c. Location -	City or Town, St	ate		
Pages ment of t ant: If its ury or of	4 ☐ Donation 5 ☐ Other (Specify)					8/21/99		WN, PA.			
permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is: eny Injury or other treu once.	21. Signature of Funeral Service License	ee O	22	Name and A	ddrass of Facility H. BARBER	FIINERAL	HOME				
207299	murie	4. Dar			OX 5038, L			20882			
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the						Appro	ximate al Between		
Physician	and only of mount land of the only of								t and Death		
/Medical	tmmediete Ceuse (Finel disaase or condition	MCTATATI	c pace	0110	CARCINO	MA		18.	MONTHS		
Examiner	resulting in death)	Due	to (or as a conseq	uence of):							
_ =								1			
are be executed hysician and the burial-transit	Sequentially list conditions,	Due	to (or as a conseq	uence of):				1			
	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Couse (Disease or Injury	C									
physician and sthe burial-tra	that Initiated events resulting In death) Last	Due	to (or as a conseq	uence of):				1			
as that the death certificated by the attending be detached for use a by Physician/Mr		J			W. Park			1			
the a the a hed f	Part II. Other significant conditions con	tributing to death but no	t resulting In the u	nderlying ceus	e given In Part I.	23b. Dtd 1	lobacco use cor	ntribute to the c	ause of death?		
that the led by the detache						10	Yes 2 No	3 Probably	4 🗌 Unknow		
been signed by the attendir should be detached for use leted by PhysicianA											
the law requires the last been sign, page 2 should be Completed by							an autopsy med?	24b. Were sui	prior to on of ceuse		
8 8 0								of deeth?)		
page Com						101	res 20 No	1 🗆 Yes	2 No		
this cartificate har all director, page	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o	ne)				
000	1 ☐ Yes 2 No	lospital: 1 Inpatient	2 ER/Outpetier	t 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 Oth	er (Specify)			
ter the neral nera	27. Manner of Death 1 2 Natural 5 Pending	28a. Dete of Injury (Month, Dey Ye	ar) 28b. Time of	28c.	Injury at Work?	28d. Describe I	now injury occur	ed			
To the choopids or Amending Physician Structure of the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	2 Accident Investigation			М	1 ☐ Yes 2 ☐ No						
To the Hospital or Attending In with the About a first death. To the Funeral Director: After completely filled in by the funer completely filled Certification:	3 Suicida 6 Could not be determined	28a. Place of Injury - building, etc. (S	At homa, farm, str pecify)	aat, factory, o	ffice	28f. Location (S City or Tox	Straet end Numb vn, Stete)	er or Rural Rout	a Number,		
Cer in Cer											
n 24 hound he Funer pletely fill edical		ner: On the best of my							ause(s)		
in 24 the F	one) and manner statad.										
within To the	29b. Signature and title of certifier)		21	canse number		29d. Date signe	- 10			
	Chite year	M·V.		04	2452		AUGUST	18,	777		
(4)											
54	30. Name and address of person who co	mpleted ceuse of death	(Item 23a) (Type,	Print) Dr	CHITRI	A AT	A GOPA	M.D.			
54	30. Name and address of person who co	empleted ceuse of death	(Item 23a) (Type,	Print) Dr.	17E 327	OLNEY	A GOPA	0832			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Month 08 Q Q 8:10 PM Evangelina Sanchez /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 8, 1923 9. Birthplece (State or Foreign Country)
El Salvador 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2₩F 76 Yrs 212-27-3461 **Director** Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at MD Silver Spring 1 ☐ Yes 2 PNo Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 12305 Valleywood Drive El Salvador Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer or Department of Health end Mental Hygiene. If item 27 is marked other than "natural", or item 1 Never Married 2 Married Specify: White X Yes 2□No SpecifyEl Salvador Baltimore, Maryland 21215-0020 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Arcadia Sanchez Francisco Polio 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 Rosalio Fernandez 12305 Valleywood Drive, Silver Spring, MD Husband 20b. Place of Disposition (Name of cemetery, crematory or other placa) Aug 26 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 6 La Union, El Salvador injury Intipuca Cemetery 1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licans 22. Name and Address of Facility FRANCIS J. COLLINS FUNERAL HOME INC any ir IRACY 500 University Blvd. W. Silver Spring, MD 20901 ruver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Betw Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner Due to (or es a consequence of): deeth certificate be executed attending physician end for use as the burial-trans Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events MYOCARDIAL Box 68760. resulting In deeth) Last P.0. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 | Yes 2 | No 3 | Probably 4 | Unknown Division of Vital Records. þ 2 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate hes 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ₺ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ⊠'inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29e. Certifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature agt title of certifier AUGUST 18 1999 M 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PORKUMY GREGEBELT MARYLMO2070 ONYGIACA 7325A HARROVER 31. Date filed (Month, Day, Year) AUG 19 32. Registrar's Signature State 1999

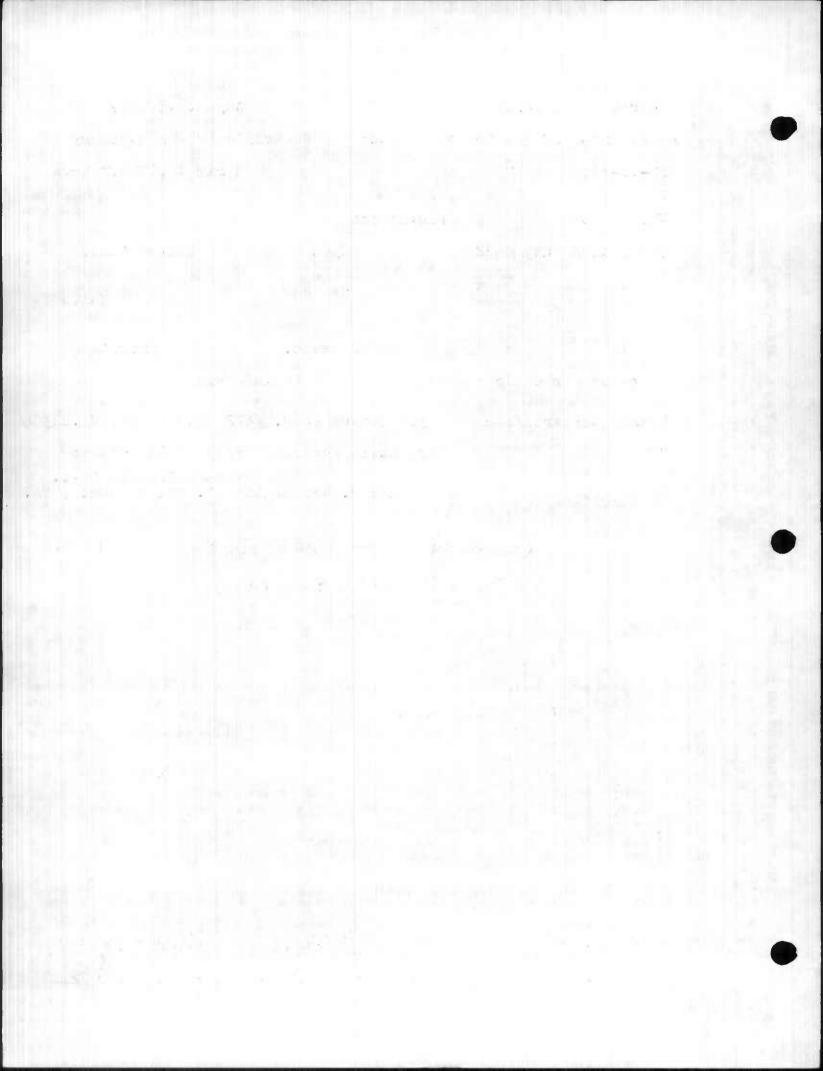
Registrar



State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

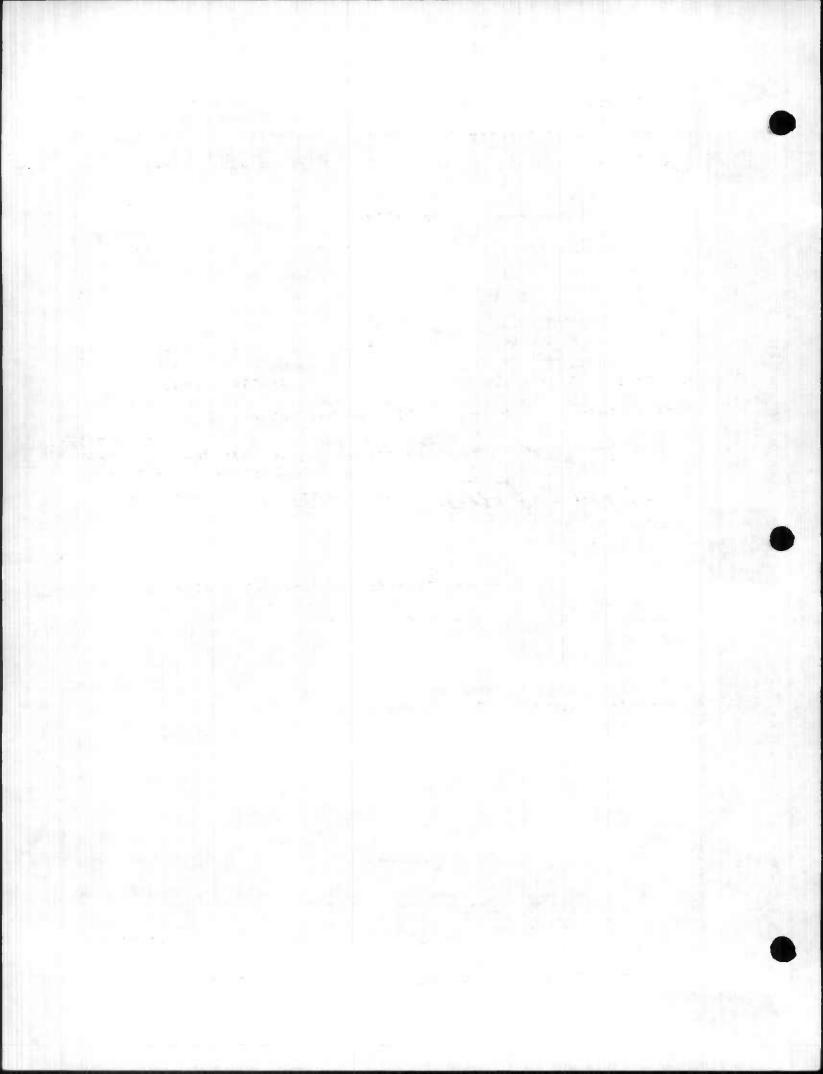
Certificate of Death 1 Decedent's Name /First Middle I ast 2 Date of Death 3. Time of Death **Physician** 2:20AM Dorothy 13,1999 Schwartz August /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Months 1□M 2DCF Days Hours Min 086-10-1109 88 New Director 18,11 York Usuel Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1⊠Yes 2□No Director VA. None Alexandria 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 22304 307 Yoakum Pkwy #422 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If Item 27 Is marked other than "natural", or han 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes ŽONo Specify: Specify: by 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Assoc. Private 17 Father's Name /First Middle Last 18. Mother's Name (First, Middle, Maiden Sumame) Abraham Merochnich Katia Kobitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 307 Yoakum Pkwy. #422 Alexandria, VA.22304 Edward Schwartz/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MDBuriel 2 Cremetion 3 Removal from State 8/15 Falls Church King David Memorial 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility end Fundful Service Licens Pearson Funeral Home. 472 N. Washington St. Falls Church, VA. +4 C N • Wasnington St • For shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** GANGRENE OF LEFT FOOT /Medical Immediate Cause (Finel 10 DAYS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): DIABETIC MICROANGIDPATHY Examiner ician and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Due to (or es e consequence of): 88 usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA, VASCULAR à 24b. Were autopsy findings evailable prior to 24e. Was en eutopsy Completed completion of cause of deeth? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To Aftar this 28e. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 D Natural 2 Accident 5 Pending Investigation aftar death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homleide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) end manner stated. 29a. Cartifier edical (Check only one) To the F within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of continu 18084 30. Nema and eddressyof person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD 20852 MONTROSE RD 6121 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 17 1999 Registrar



	State of Maryland / Department of Health and Certificate of Death		giene	27264								
Physicia	1. Decedent's Name (First, Middle, Last) Beatrice Shapiro	2. Date of Dea Month August	nth Day Y	3. Time of Death 12:55pm								
/Medica Examine	4. C. T. Alexandra de la Charle	Location of Death	. 1									
Examin	Hebrew Home of Greater Washington Rockvil	1e	Monte	omery								
Funeral Director	5. Social Security Number 087-30-0879 6. Sex 1 M 2 F 85 Yrs. 6. Sex 1 Months Days Hours Mir		Year) 9,1913	Birthplace (State or Foreign Country) New York								
8 .	Usual Residence of Decedent 10a, Slate 10b, County 10c, City, Town or Location			Land ballet On the he								
he Maryland 28a-f show offilied at				10d. Inside City Limits								
the h	MD Montgomery Rockville 10e. Street and Number 6121 Montgoop Rd		10g. Citizen of Who	x								
Sa or	6121 Montrose Rd. 20852		USA									
5-0020 72 hours atter death with the Maryla natures", or leans 23s or 28a-f shor disal Examines must be notified at	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Married 1 Yes 2 No 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White								
Nouna Pour	Year or Detes:											
21215-0020 d within 72 hours at genu. rr than "natural", or rr tha Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) To a complete of the secondary (0-12) To a complete of the secondary (0-12) College (1-4or 5+)	orking	16b. Kind of Busin	ness/industry								
2121 d within pieru. t than '	Elementery/Secondary (0-12) College (1-4or 5+) Clerk		Book Co	mpany								
and 2 the filed that Hygin d other	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle,										
ylar ould b Menta	Ste	lla He	useu									
Mar nd 2 sh out, and 27 is m	19a. Informant's Name/Relationship (Type, Print) Alice Klein / Daughter 19b. Meiling Address (Street end Number or F			ete, Zip Code)								
nor oth	20a. Method of Disposition 1 🖾 Burial 2 Cremetion 3 Removel from State 4 Donatlon 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) We Montefiore Cemetery	Date 8 / 1 9 / 9	20c. Location - Cit LON	y or Town, State g Island, York								
Baltin semit. P. bepartme mportant ings.	21. Signature of Poheral Service Licensee 22. Name and Address of Facility T	akoma F	uneral									
0 33558	Hopey 8. Loffins 254 Carroll St.	NW Was	hington	DC 20012								
Physician	23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Approximate Intervel Between Onset and Death								
/Medical Examiner	Immediate Ceuse (Finel disease or condition Pneumonia		l week									
	resulting in death) Due to (or es a consequence of):											
De in	Arteriosclerotic Cardiovascular disease years											
exactu n and al-tra	Arteriosclerotic Cardiovascular disease Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Arteriosclerotic Cardiovascular disease Due to (or es e consequence of): Hypertension C											
8760, cate be executed chystician and the bunal-transit	Cause (Disease or Injury that initiated events			years								
death certifica	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease											
d for u	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did 6	ohacco use contr	bute to the cause of death?								
	Chronic obstructive lung disease			☐ Probably 4 ☐ Unknown								
	and the state of t											
Deen should			an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?								
x 2 5 5		1 U Y	es 210 No	1 ☐ Yes 2 ☐ No								
otor.	25. Wes case referred to medical 26. Place of De	eeth (Check only o	ne)									
Of VIta Physician: this certific and director.	Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing	Home 5 ☐ Resid										
ding P. Affect funeral	27. Manner of Death 1 Natural 5 Pending 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Accident investigation	28d. Describe h	ow injury occurred	75 4 4 40								
DIVISION Of VITAI or Attending Physician: 7 after death. Director: After this certificat d in by the funeral director, p	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Accident determined 28e. Dete of Injury 28e. No 28e. Plece of Injury - At home, farm, street, fectory, office 28e. Plece of Injury - At home, farm, street, fectory, offi	28f. Location (S City or Tow		or Rural Route Number,								
25.40	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred and menner stated.											
To the To the	29b. Signeture and title of certifier 29c. License number		29d. Date signed (the second second								
10	Frakle D23958		8/18/	799								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burt I. Feldman, MD 6105 Montrose Rd , Rockvi	ille MD	20852									
State Registra	NIC 9 0 1000											

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Margaret Sobchak 12 August 1999 2:32pm /Medical Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6508 Bonnie Brae Road Sykesville Carroll ff Under 24 Hrs. 8. Dete of Birth
Houra Min. July 12, 1919 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Months Days 80 188-01-6313 Yrs. Pa. **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location "naturel", or items 23s or 28s-1 show Md Carroll Sykesville 1 Tes 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6508 Bonnie Brae Road 21784 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a any Injury or other traumatic event, the Medical Examples must because. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ≥ ∑No If Yes, Give Yeer or Dates: 11. Meritel Stetus Was Decedent of Hispanic Orlgln? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: white P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Elementery/Secondary (0-12) Homemaker 12 Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) John Bozym Frances Bartol 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Frank M. Sobchak (son) 6508 Bonnie Brae Rd. Sykesville MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other piece)
Lake View Memorial Park 8/16/99 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriei 2 ☐ Cremation 3 ☐ Removal from State Sykesville MD 4 Donation 5 DOther (Specify) 22. Name and Address of Fecility Haight Funeral Home & Chapel 21. Signeture of Funeral Service Licensee P.O. Box 195 Sykeville MD 21784 lan 23a. Part 1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate intervat Between Onsel **Physician** tmmediate Cause (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medicai Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760. Due to (or es e consequence of): BS attending 980 ò 23b. Did tobacco use contribute to the cause of death? P.O. ed by the a Part It. Other algoritions conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? has paga 1 Yes 2 No 2 1 No After this certificata To the Hospital or Attending Physician: Be 25. Waa case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 DNatural 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: complataly filled in by the 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomlcide 1 Sertifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(a) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a, Certifier edicai 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifler 29c. License number 30. Name end address of person who completed cause of death (frem 23a) (Type, Print) 224 4 Jashington Heights, Wistminster, MD21157

State Registrar 31. Date tiled (Month, Day, Year)

AUG 1 6 1999

32. Registrar's Signeture

Alle Francis

			State of	Maryland /	Cei	rtificate	of Death of Death	and N h		giene 💮 Reg. No.	9 2	72	66
П	Physici	an	Decedent's Neme (First, Middle, Last)						2. Dete of De	Dev	Year	3. Tim	e of Death
u	/Medic		Ethel Mae Treptor				.,		AULUST	17,1	999	5	ומוןי
и	Examir	ner	4e. Facility Name (If not institution, give street and num						Location of Deeth 4c. County of De				
Н	F	-	5. Sociel Security Number 6. Sex 7	Age (In yrs. lesi	hirthriau)	If Under 1 Y		er 24 Hrs.	B Dale of Birt		KF ar	-	do ou Comina
	Funerai Director		220-09-6133 1□ M 2X F	84	Yrs.		eys Hours		8. Dete of Birt (Month, Det 01/12/	y, Year) 1015	PA	try)	le or Foreign
	P .		Usuel Residence of Decedent						01/12/	1313	171		
	show	Ļ	10e. Stete 10b. County	10c. City, To	own or Lo	ocation					11		e City Limits
	he M	Director	MD Harford	Havre	de	Grace				Yes 2□N		res 2LJNo	
	a or	Ö	10e. Street end Number			10f. Zip Co			10g. Citizen of What Country?			try?	
	heeth me 23	Funeral	505 Congress Ave. Apt 2	10 lent Ever In U.S.	21078 S. 13. Wes Decedent of Hispenic Orlgin? (Specif				ecify Yes or No-	USA 14 Rec	e - Americ	an Indier	,
0	ofter o	FU	1 Never Married 2 Married 1 Yes 2	es?	If Yes, specify Cuban, Mexican, Puerto			Rican, etc.)	Ble	ck, White,		,	
21215-0020	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "naturel", or items 23a or 28a-1 show int, the Medical Examinet must be notified at	d by	3 X Widowed 4 □ Divorced If Yes, Give Yeer or Det		1 ☐ Yes 2 🔏 No Specify:		у:		Specif	Wh	ite		
5-	"natu	Completed	 Decedent's Education (Specify only highest grade completed) 	16	(Give	dent's Usuei O kind of work d	one durina ma	ost of work	ing	16b. Kind of B	usiness/Ind	lustry	
12	withir ene. then	ошо	Elementary/Secondery (0-12) Cotlege (1-4	4or 5+)		DO NOT use re	etirea)			Docto			
	filed Hygi other ent, I	Be Co	17. Father's Neme (First, Middle, Last)		wa	itress	18. Mot	her's Nem	e (First, Middle,	Resta Meiden Sumer			
Maryland	Mental Mental arked o	To B	George Arthur Davis				Mai	rv TI	homas				
lan	2 should and Men Is marke surretic		19e. Informent's Neme/Relationship (Type, Print)	1	9b. Maitir	ng Address (St		4	al Route Numbe	or, City or Town	Stete, Zip	Code)	
	Health m 27		Evelyn Richardson- Siste					St.	, Havre	de Gra	ace,	MD	21078
100	Pages 1 nent of H int: if ite		20e. Method of Disposition 1X Burlel 2 □ Cremetion 3 □ Removel from SI		of Dispo	sition (Neme onetory or other	pleca)	1	Dete	20c. Location	City or To	wn, Stete	
altimore,	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Manylen Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Manylener of them 27 is marked other than "naturel", or items 23a or 28a-1 shown proportant: if item 27 is marked other than "naturel", or items 23a or 28a-1 shown in Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licansee	Ange		II Ceme			/20/99	Havre o	de Gr	ace,	MD
Ba	Departme Departme Importan eny Injur		21. Signature of Furnaral Service Licansee	0-	Mi	Name end A	Smith	Fune	ral Hom	ne, P.A			
	_		23a. Pack Enter the disease, or complications that call	used the death. D) 12	23 S. W	ashing	gton,	Havre	de Gra	ce, N	Approxi	
	Physician		23a. Part Enter the disease, or complications that can shock, or heart feiture. List only one cause on each	ch line.			-jg, 000		or racpitatory of	,		Intervel	Between nd Deeth
	/Medical	П	tmmediate Cause (Final disease or condition	liastina	p Me	255/1	Rt. C	olon	- can	cer		46	ar
	Examiner	L.	resulting in deeth)	Due to (or es	e conseq	juenca of):					-		
	nsit	Examiner	b			,							
.	icata be executed physician end is the buriel-transit	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due to (or es	e conseq	uenca of):					i		
8760,	ita be iysicia ne bur	dicai	Ceuse (Disease or injury that Initiated events resulting In deeth) Lest	Due to (or es	e conseq	uenca of):							
	artifica ing ph e as th		resulting in deeth) cest			·							
Box	ath ce	ian/	d										
o	thet the death certified by the ettending deteched for use an	Physician/M	Pert ii. Other significant conditions contributing to dee	th but not resulting	g in the ur	nderiying cause	given In Per	t I.	23b. Dld t	obacco uae co	ntribute to	the cau	se of death?
J	es thet tigned by be deter	by Ph	At	not FI	5 F	- Cutt	2		101	/es 2□No	3 ☐ Prob	ably	Unknown
or Vital Records,	.E 00 0		7) •	mentin persen					24a. Wes				sy findings
ဝင္	2 S S	piet	ge)	menn	J				perfor	meg?	cor	npletion leath?	of cause
ř =	The ate h	Completed	Hy	perten	sen	C			1 🗆 Y	es 20 No	1	Yes :	2 No
Z Z	Attending Physician: The rideath. ector: After this certificate by the funeral director, par	Be	25. Wes case referred to medical exeminer?						h (Check only o				
0	Physic ral dir	. To	1 ☐ Yes 2 No Hospitat: 1 ☐ fn; 27. Menger of Deeth 28e. Dete of	toium 29h	Outpetien	1	Other:	Jursing Ho	me 5 Resid)	
Division	ding Physith. After this funeral di	tion		Dey Year)	Injury		Work? 1 ☐ Yes 2 []No	Zou. Describe in	ow injury occur	160		
N S	l or Attendil after death. Director: A d in by the fu	Certification:	3 Sulcide 6 Could not be determined 28e. Pleca o	Injury - At home,	ferm, stre	eet, fectory, off	ica		28f. Location (S		per or Rura	Route A	lumber,
בֿ	tal or al Olr led in	Cer	- Entitled	, etc. (Specify)					City or Tow	ri, Siele)			
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	Medical Examiner: On the bes	is of exemination e	vledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. ion end/or Investigation, in my opinion, deeth occurred el lihe time, dete end pleca, end due to the ceuse(s)								se(s)
	thin 2 the 1	Med	one) end menne 29b. Signeture end little of certifier	r steted.			ense number			29d. Dale signe			
	F 2 F 8			10	40	A. D	DU2	110		DA A	77-6	ay, 100	.,
	0		30. Name end eddress of parson who completed cause	of deeth (item 234	(Cyne	Print)	シリン	113		8 /	/ /	/_	
	~		30. Name and address of parson who completed cause 6 15 S-Union 31. Date filed (Month, Dey, Year) 32. Reg	Ave.	H	lavre	De	Sis of	ce, 1	10,	2/0	28	
	Star Registra	-	31. Dete filed (Month, Dey, Year) 32. Rec	istrer's Signeture	4				-				

State of Maryland / Department of Health and Mental Hygiene

						Cei	titicat	e of	Death			Reg. No.			
	Physician /Medical	1. Decedent's Nam James		readway	, Jr.						2. Date of D Month August	Day		3. Time of Death 10:30A.	
6	Examiner	4a Facility Neme (/	If not Institution, giv	re street and numb	ber)				4b. City, To	wn, or L	ocation of Dea	th 4c.	County of E	Death	
	LAUMINICI	4703 01	ympia Av	enue					Beltsville Prince Geo					George's	
	Funeral Director	5. Social Security N 412-40-1		Sex 7	. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Oct • 17	y Year)	9. Te	Birthplace (State or Foreig Country) Ennessee	gn
113	e	Usual Residence of													
	0 H	10a. Stata	10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limit	ls
	Mar Mar Mar Mar Mar Mar Mar Mar Mar Mar	Maryland	Prince	George's	Belt	svil	ville							1 ☐ Yes XXXN	lo
	te death with the Maryland thems 23e or 25e-f show the must be notified at tuneral Director	10e. Street and Nur 4703 01	mber Ympia Av			10f. Zip Code 1 20705						10g. Citizen of What Country? United States			
21215-0020 d willhin 72 hours after death	Example Dy F	11. Marital Status 1 Never Marri 3 Widowed	lent Ever in U,S. es? ON es:	If Yes, specify Cuban, Mexican, Puèrio Rican, etc.) 1 ☐ Yes Ž\\ \begin{align*} \text{No Specify:} \end{align*}								American Indian, White, etc. White			
20	ratur dical	(Spec	1	16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business/Industry United States					
212	ed within 72 ho ygiene, er then "netur t, the Medical. Completed	Elementary/Seco	ondary (0-12)	College (1-4	lor 5+)	Inspector						Postal Service			
		17. Father's Neme	(First, Middle, Last)		18. Mother's Name (First					e (First, Middle	t, Middle, Maiden Surname)			
/lan	Mental Personal Perso	James 1	M. Tread	lway, Sr	·						War	d			
Maryland	alth and N		ame/Relationship (Treadway				e as		and Numb	er or Rui	ral Route Numi	ber, City o	r Town, Sta	te, Zip Code)	,
Baltimore	rages 1 a nent of He ant: If Item ary or othe		position Cremation 3 5 Other (Specif		ceme	etery, cren	sition (Nam natory or o ashin	ther pla		eter	Date y 8/19/			or Town, State phi, Maryland	1
Balt	Departs Departs Imports any inja ance	21. Signature of Fu	21. Signature of Funeral Service Licensee								t Funer			P.A. aryland 2070)5
	11112	23a. Part1. Enter to shock, or hea	23a. Part1. Enter the diseasa, or complications that caused the death. Do shock, or heart feilure. List only one sause on each line.						ng, such as	cardiac	or respiratory	arrest,		Approximete Interval Between	

Physician /Medical Examiner

Immediate Cause (Final disease or condition rasulting in deeth)

Dysrhythmia

Due to (or as a consequence of):

Atherosclerotic Cardio Vasue (a) Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of):										
that initiated events resulting in death) Last	Due to (or as a consequence of):										
	1				1						
Part II. Other aignificant conditions con	tributing to death but not resulting	ng in the underlying o	ause given in Part I.	23b. Did tobecco use co	ntribute to the cause of death?						
Atrial Fibi	illation,	Diabe	etes	1 Yes 2 No	3 Probably 4 Unknown						
Hellitus,	Hyperte	nsin	2	24a. Wes an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?						
Hyperlipio	laned			1□ Yes 2 No	1 □ Yes 2 No						
25. Was case referred to medical axaminer?			26. Place of De	eath (Check only one)							
1 Yes 2 No	lospitat: 1 Inpatient 2 ERV	/Outpatient 3□ DO	OA Other: 4 Nursing	Home 5 Residence 6 □Ott	ner (Specify)						
27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of Injury M	28c. fnjury at Work? 1 Yes 2 No	28d. Describe how injury occur	red						
3 Suicide 6 Could not be determined	28e. Plece of Injury - At home building, etc. (Specify)	, farm, street, factor	y, office	281. Location (Street and Numb City or Town, State)	per or Rural Route Number,						
29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one) 12 Medical Examination (Check only one)	sician: To the best of my knowled her: On the basis of examination and manner stated.	dge, death occurred and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause(s) and mourred at the time, date end place,	anner as stated. and due to the cause(s)						
29b. Signature and title of certifier Agnne A.	Gaynes	1410,	b 25 442	29d. Date signe	d (Month, Day, Year)						
30. Name and address of person who co	mpleted cause of death (Item 23	(Type, Print)		22- 1 0	110 2000						
Lynne Gaynes, 1	U.D., 14201 6	aure Pe	uk of #	223, Caurel	20101						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burier-trensit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

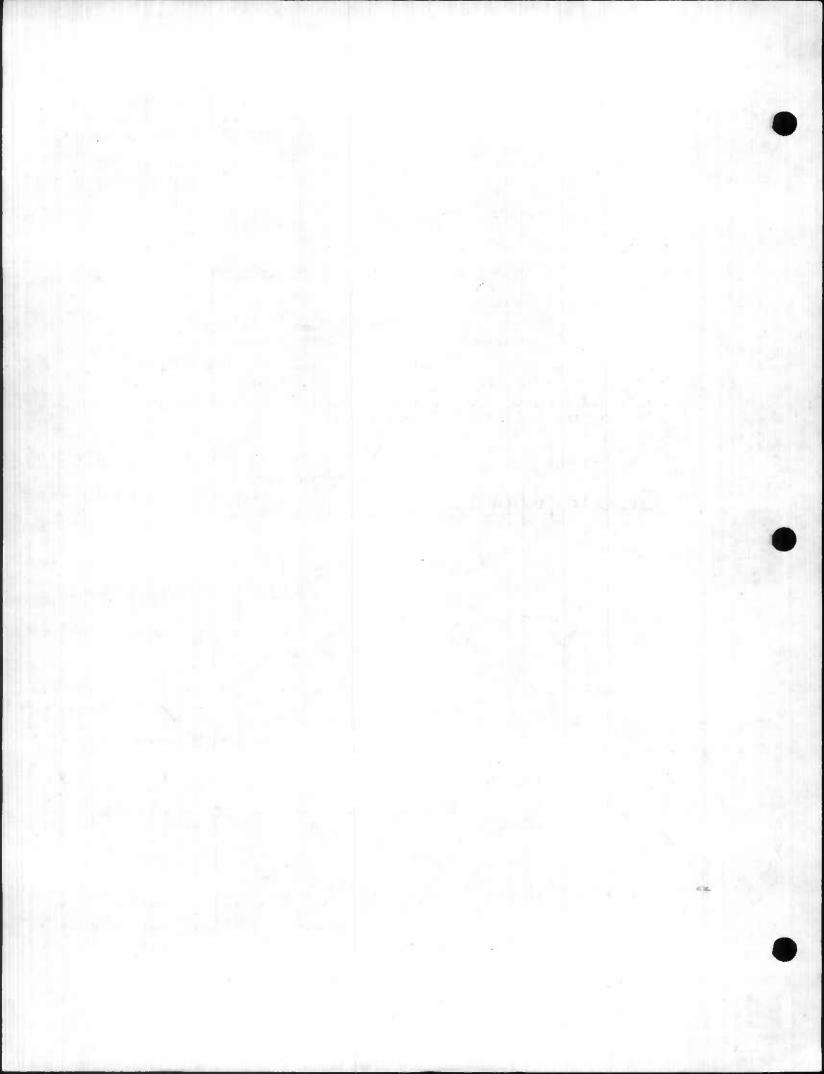
AUG 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

499 Gaynes, M.D., 14201 (access)

31. Date filed (Month, Day, Year)

32. Begistrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** AUGUST 1999 14, 8:05pm SAMUEL LESTER TIMBERS /Medical 4b. City, Town, or Location of Death 4s Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY Mariner Health at Circle Manor Kensington If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) July 7,1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 □ F 91 579-09-5788 Virginia Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ahow the Maryla MD Montgomery Rockville TX Yes 2 □ No Directo 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itsms 23a or 20850 U.S.A. 222 Elizabeth Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. Illed within 72 hours after Hyglene. Other then "netural", or its 1 ☐ Never Merried 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Rockville 7th Foreman permit, Pages 1 and 2 ahould be file. Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha Thompson James Timbers 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora J. Timbers (Wife) 222 Elizabeth Ave., Rockville, MD 20850 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State MBurial 2 ☐ Cremetion 3 ☐ Removel from State 18/20/99 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses ROCKVILLE, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart felidire. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Physician/Medicai Due to (or es a consequence of): 88 for use as 99 Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 1 No 3 □ Probably 4 □ Unknown signed t þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 : 2 No 1 ☐ Yas 2 ☐ No 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Aftert or Attending 1 Netural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: d in by the 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 D Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in To Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end manner stated. 29a. Certifier (Check only one) 29d. Data signed/(Month, Day, Year) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) KENSINGTON 3720

Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Day, Year)

AUG 17

1999

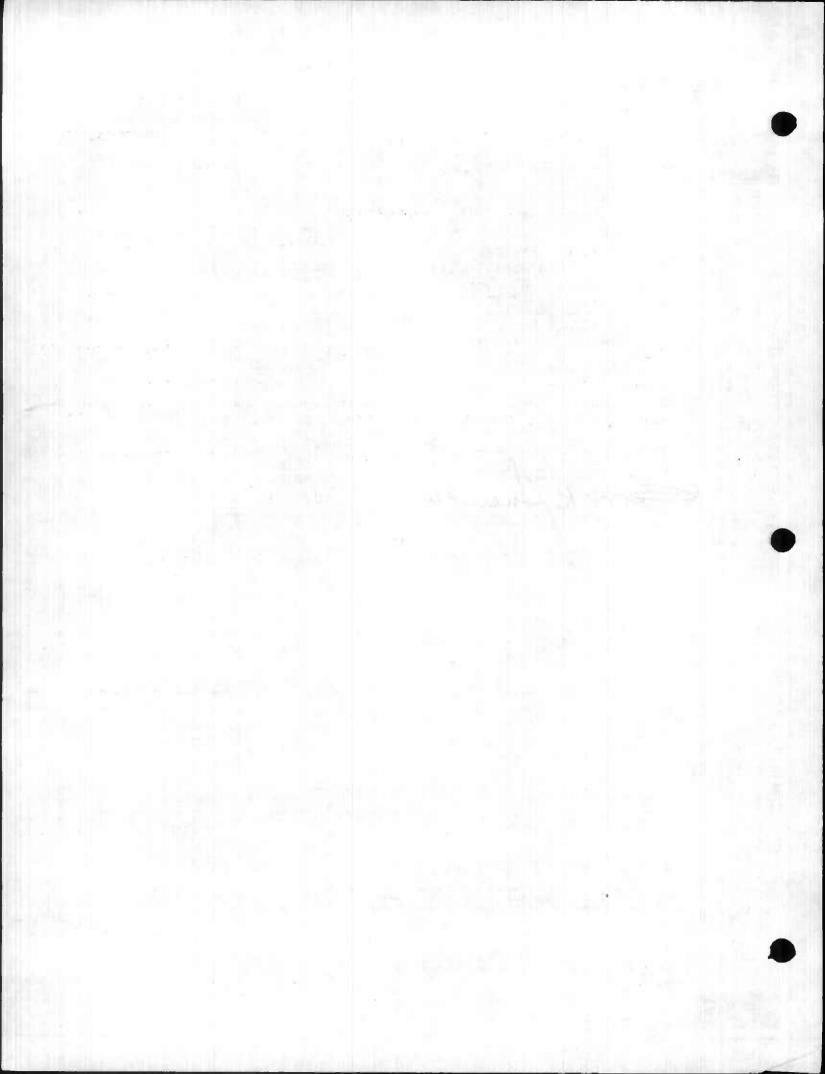
32. Registrar's Signature

Deneva

Box 68760.

(1)

State

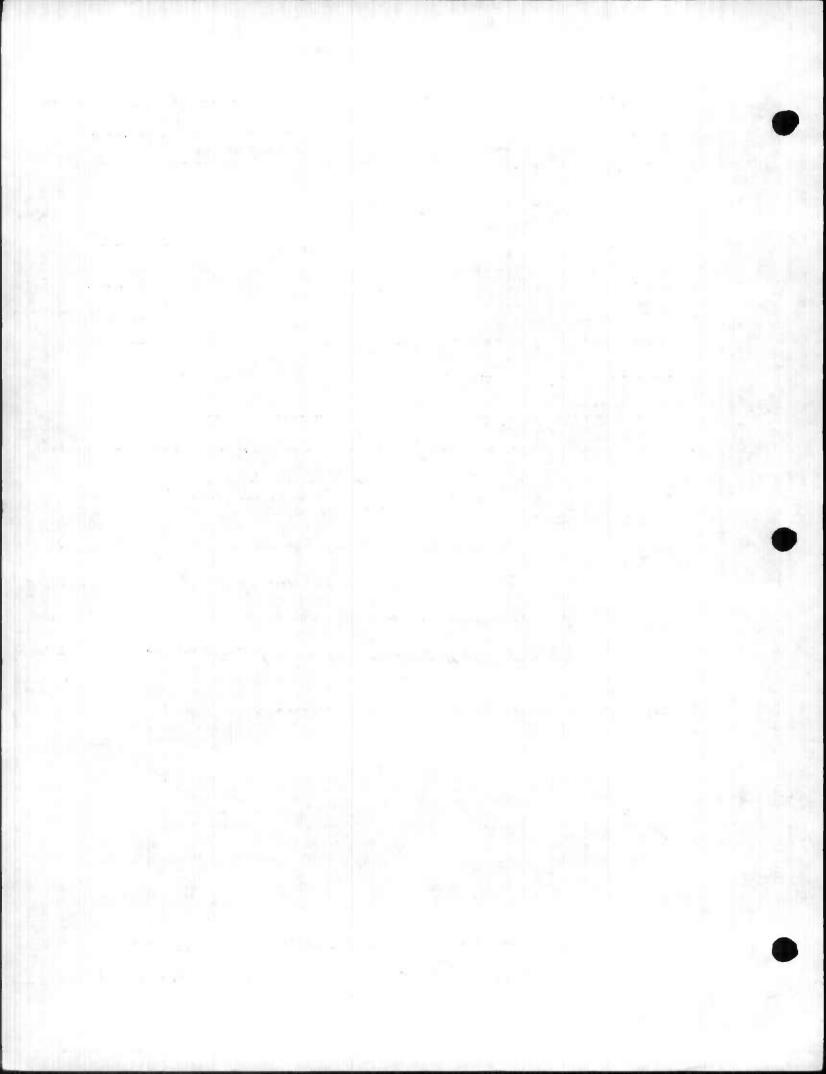


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician CORNEL IA HALLOWELL **THOMAS** AUGUST 14, 1999 2:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SANDY SPRING 315 ASHTON ROAD MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth JUNE 27, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 20/F 009 12 0858 78 MARYLAND Yrs Director **Usual Residence of Decedent** 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY MD. SANDY SPRING 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 315 ASHTON ROAD 20860 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give WHITE 21215-0020 8 1 Yes 2 No Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER HOSPITAL Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be the ment of Health and Mental H aint: if them 27 is marked oth lury or other traumatic even å FREDERIC THOMAS FL.ZA BENTLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGIA MAITLAND, PERS. REP. BOX 35, SANDY SPRING, MARYLAND 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. METROPOLITAN CREMATORY 8/15/99 ALEXANDRIA, VIRGINIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician La aio Respi exon /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Please effersions The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Failure Meant Box 68760. Physician/Medical mexastakie Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? Breast. 1 Yes 2 No 3 Probably 4 Unknown ademo Co. Cludina Records, á page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 TYes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Daeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To # 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? After Division 1 Natural or Attending 5 Pending investigation To the Hospital or Attending Within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certified (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number Lauless 125410 D AUGUST 14,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DJ. LAW 1655 MW. Suile 126, 18111 PRINCE Philip DRIVE Olvey MD 20832

State Registrar 31. Date filed (Month, Day, Year) AUG 16 1999 32. Registrar's Signature

Sparks



99-4833-033

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

W. ALLEN

State of Maryland / Department of Health and Mental Hygiene

A • SATITICAL							iaic oi	IAICTI	ylair	a / Department of rican	400
TURNER	AMEND	ITEMS:	#23	PART	I,	27,	28A-F	PER	MEO	G77 Certificate of Dea	ith

JT	JRNER AM	END ITEMS: #23 PART I, 2		G77 C8	rtificate of	Death		g. No.	a Time of Death			
	Physician	Decedent's Nama (First, Middle, Last, W.	Allen	2. Data of Deat Month AUGUST		Year 9:46A.M.						
/Medical		4a E Sity Nama (If not institution, giva		4b. City, Town, or I		4c. County o						
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 23s-f show any injury or other traumatic event, the Medical Examinet must be notified at once. To Be Completed by Funeral Director	4445	PT 104	FORESIVI									
	5. Social Security Number 6. Sec	If Undar 24 Hrs. Hours Min.										
	5/9-96-0939	M 2□F 37	30000	March 2,1962 England								
	P 8-4	Usual Residenca of Decedent 10a. State 10b. County	10c. Cit	10c. City, Town or Location				10d. Insid				
	Maryland Prince Ge		1 Yes 2 No									
	10e. Street and Number			10	Og. Citizen of W							
	4415 Rena Road Apt	. 104				U.S.A.						
	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	,S. 13.	Was Decedent of H If Yes, apecify Cub	tispanic Origin? (S	pecify Yes or No-		- American Indian, Whita, atc.				
	or h minh	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1□ Yes 2H No		Specify:		White			
	d b		Yaar or Datas:									
	15. Decedent'a Edu (Specify only highes! grad	16a. Dece	edent's Usual Occup e kind of work done DO NOT usa retire	pation during most of wor with	king	iness/Industry						
	the Man	Elementary/Secondary (0-12)	College (1-4or 5+) +1	n Worker				al #5				
	17. Father's Name (First, Middle, Last)	110.	II WOLKEL	18. Mother's Nan	ne (First, Middle, A							
	W. Allen Turner,	III	Valerie	rie J. Ring								
	19a. Informant'a Name/Relationship (Ty					Rural Route Number, City or Town, State, Zip Code)						
	and and and and and and and and and and	Valerie J. Turner							n VA 22202			
	20a. Method of Disposition 1 DBurlal 2 Cremation 3 DF	lamoval from State		osition (Name of amatory or other pla				City or Town, Stata				
	4 Donation 5 Dother (Specify) Resurrection Cemetery Aug. 23,1999 Clinton, Maryland											
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735											
Physician /Medical Examiner	23a. Part1. Enter the disease, or compl	ications that caused the dep	Do not er	nter tha mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between				
	Physician	23a. Part1. Enter the disease, or complications that caused the dear Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
	tmmediate Cause (Final disease or condition	AMOBARBITAL A	ND ALCO									
	100	resulting in death)	Due to (o									
	i i		,									
ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit beleed by Physician/Medical Examinar	and I-tran	Sequentially list conditions, Due to (or as a consequence of):										
	be dician buris	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										
	nificate ng phys as the	resulting in death) Last	Due to (or									
Box	attending for use a		1									
m	death e atte od for	Part If. Other significant conditions cor	ntributing to death but not res	ulting in the	underlying cause git	ven in Part f.	23b. Did to	bacco usa con	tributs to the cause of death?			
15, P.O. BOX res that the death ce signed by the attendi be detached for use by Physician/		- Init C C Still Co. S. C. C.		1 Yea 2 No 3 Probably Unknow								
	igned be de by I								, ,			
ecords, law requires the as been signed to be controlled	The law requir				performed? availab		24b. Were autopsy findings available prior to completion of cause					
ec	law ras bas bas start								of death?			
ISION Of VITS trending Physician: death. stor: After this certific y the funeral director lication: To Be	The page.						1/2 Ye	s 2 No	1 Yas 2 No			
	25. Was case referred to medical examiner?	fospital:		Ort	hoe	ath (Check only on						
	POXYes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	28b. Time	INT BLI DOA	4 U Nursing F	ome 5 🕅 Reside						
	1 Natural 5 Panding 2 Accident investigation	(Month, Day Year) FOUND:	FOUND	A Wo	rk?]Yes 2∐XNo	SUBJECT INGESTED AMOBARBITAL &						
	3 Suicida 6 □ Could not be	8-18-99	ome, farm, a	treet, factory, office		281. Location (St	or or Rural Route Number,					
ă	s after a Direct of in Direct o	4 Homicide	building, etc. (Specify RESIDENCE		City or Town, State) 4415 RENA ROAD, APT. 104, FORESTVILL							
Di tospital or hours afte hours after leby filled in	Lunera Lunera pletely fille											
	leding led	one)	and manner atated.	norr end/or II								
	N CO	29b. Signature and title of certifier	1111		29c. Licens		29d. Date algned (Month, Day, Year)					
	V	1 Misdon 1	1 FT ms		0.	.C.M.E.	A	UGUST 19	, 1999			
1.0	AL	I 30. Name and address of person who co	mpleted cause of death (Item	23a) (Type	. Print)							

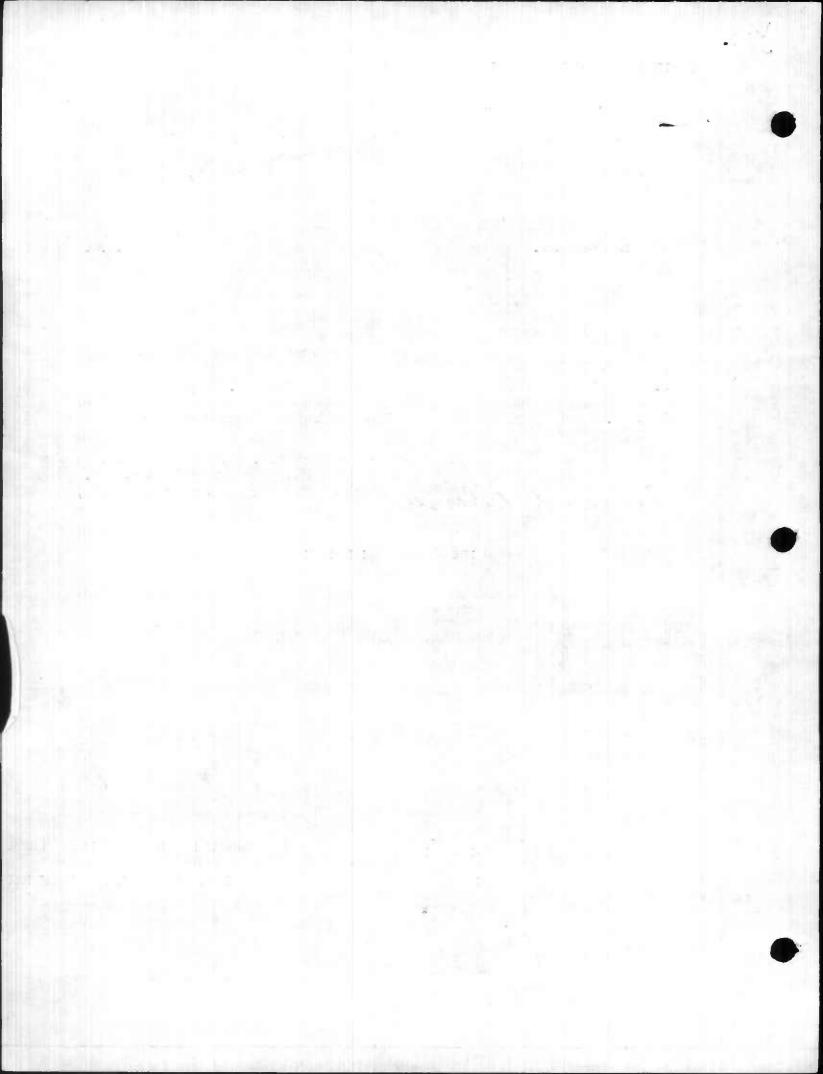
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31. Data filed (Month, Day, Year)

32. Registrar's Signature

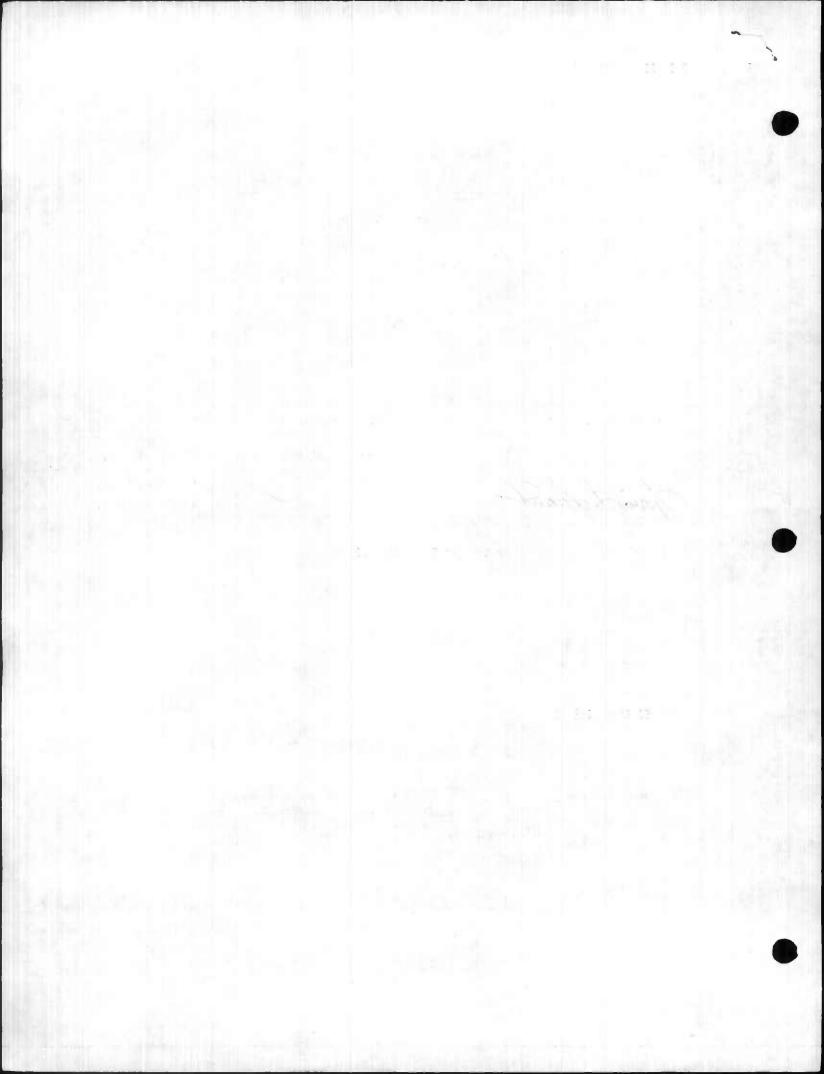
111 Penn Street, Baltimore, Maryland 21201



DHMH 16 Ray 6/95

Registrar

Freue



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O AMEND ITEMS: #1. 4A-B PER MD G775 Amend #10c,d,e,19b,8/23/99,BMW,Montg.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Vadlamudi Kutumba August 12, 1999 11:55 p.m /Medical 4b. City, Town, or Location of Death GAITHERSBURG 4a Facility Name (If not institution, give street and number)
413 WEST SIDE DRIVE #102 4c. County of Death **Examiner** 413 Westside Drive, #102 Bethesda Montgomery 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Yrs NONE 57 **Director** India Usual Residence of Decedent with the Maryland 10c. City, Town or Location Gaithersburg r 28a-f show 10a Stete 10b. County 10d. Inside City Limits 1 Yes - PONO Maryland Montgomery Directo 10a. Street and Number. West Side 10f. Zip Coda 10g. Citizen of What Country? r than "natural", or items 23s or the Wedical Examiner must be 413 Westside Drive, #102 20878 India be filed within 72 hours after death value Hygiene.

d other than "natural", or freme 23seent, the Medical Examine must Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 X Married 1 Yes 2 No þ Specify: Indian 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Agriculture Officer State Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event PRES. Gopal Krishnaiah Vadlamudi Dhanachandravathi Potluri 19b. Medica Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gaithersburg
413 Westside Drive, #102, Bethesde, Maryland 20878 19e. Informent's Neme/Reletionship (Type, Print) 413 Westside Drive, Bhuvaneswari Vadlamudi (wife) 20a. Method of Disposition
1 🗆 Burial 2 🖺 Cramation 3 🗀 Ramoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 8/13/99 Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility
Rapp Funeral Services, P.A. M00956 933 Gist Avenue, Silver Spring, Maryland 20910 Approximata Interval Batween Onset and Death 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Congestive Heart Failure 10 years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Heart Attack 10 years that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): 38 attending 980 by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown none signed b Division of Vital Records. p The law requires 24b. Were autopsy findings Completed 24a. Was an autopsy avallable prior to completion of cause of death? performed? has le 2 s certificate has director, page 2 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of Injury 1 X Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

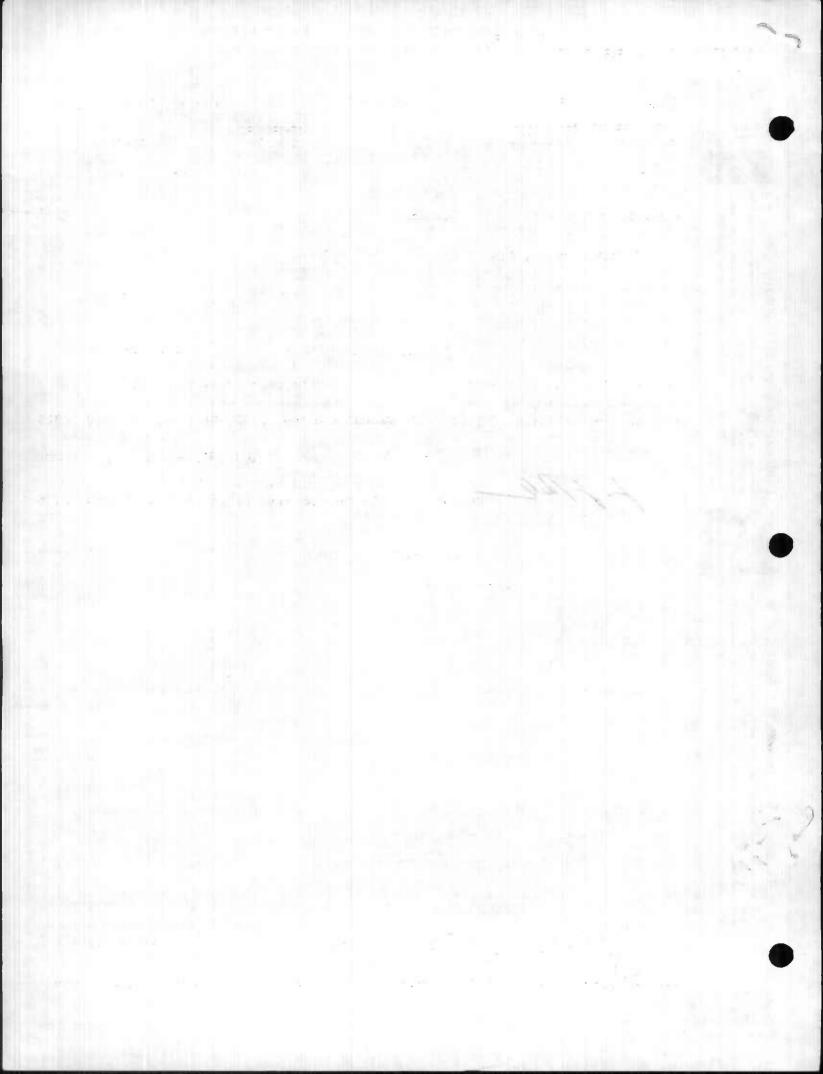
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier and manner stated. 29b. Signature a 29c. Licansa number 29d. Data signed (Month, Day, Year) D45880 August 13, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon C. Hwang, M.D., 10400 Connecticut Avenue, Suite 606, Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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DHMH 16 Rev 6/95

Registrar

AUG 16 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26, 8/18/99, BMW, Montg. Co Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10, Francisco Villalta 1999 2:35 PM Jose August /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 7209 16th Avenue Takoma Park Montgomery If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 11 M 2□ F Yrs. Director 213-15-7706 July 29, 1924 El Salvador Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 및 No Director Maryland Montgonery Takoma Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 238 1608 Drexel Street Funeral 20912 0912 death Herna Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 12. Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 natural, or ty Yes 2□ No Specify: Specify þ 3 Widowed 4 Divorced Salvadoran White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Shoemaker Shoes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be in nent of Heelth end Mental int: If New 27 is marked or 2 Jose V. Jaco Amelia Villalta 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Heelth er Important: If Item 27 is any Injury or other tran <u>Maria Elba Villalta</u> (wife) 1608 Drexel Street Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/14/99 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to for as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. I Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t 12 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 2 00 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vitai Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Home of grand-daughter Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home - 6 Mounts 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1. Netural 5 Pending investigation A hours after des.

-real Director: Attack

-real Dire 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29e. Certifier Ter Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D

State Registrar 29b. Signature apositie of certi

30. Na

KENDRICK HONDA MD 31. Data filed (Month, Dev. Year) AUG 18 32. Fingistrar's Signature 1999

and address of person who completed cause of death (Item 23a) (Type, Print)

BLADENSBURG

NO

29c. License number

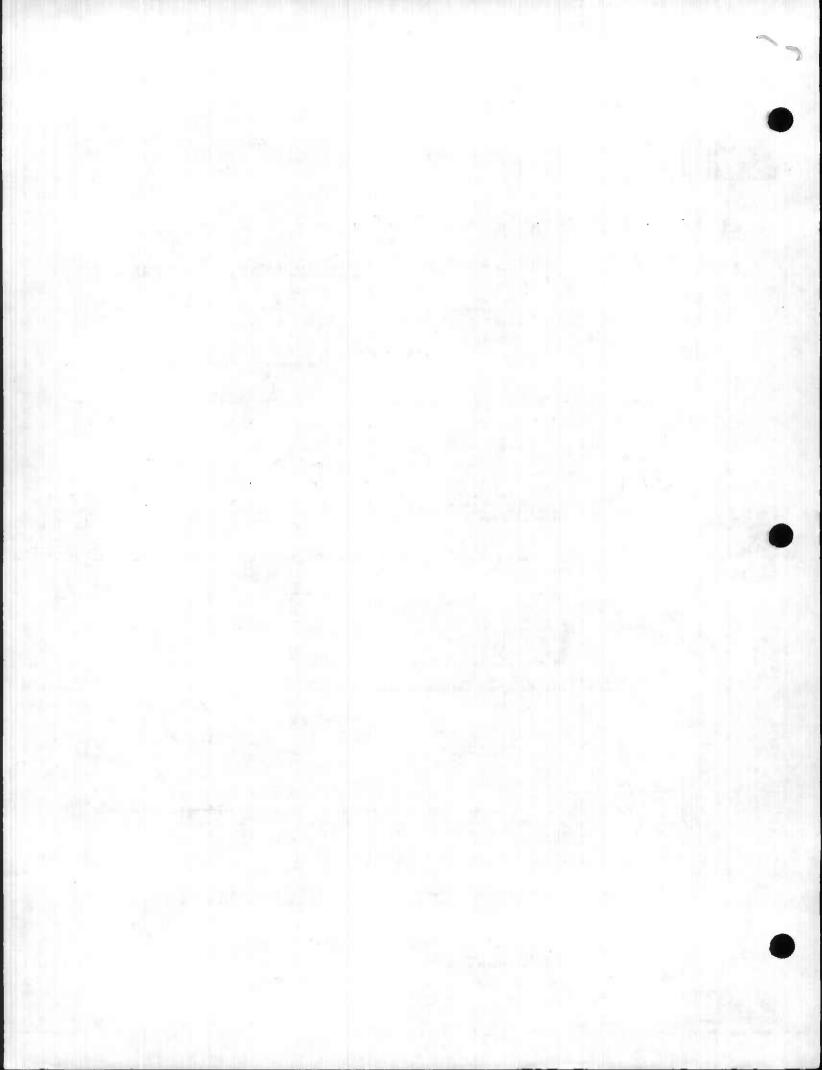
29d. Date signed (Month, Day, Year)

MD

RU.

COLMAR MANR

20722



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Darrell Robert Weaver August 12 1999 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Deys Months Yrs 79 509-16-5315 11/06/1919 Kansas Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD Harford Havre de Grace 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1036 Chesapeake Drive Apt 9D USA 21078 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕱 No 14. Raca - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Yeer or Detes: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Apartment Complex Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Edward Weaver Marjorie Bailey 19e. Intorment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2610 Thorny Dr., Churchville, MD 21028 Joyce Weaver- Daughter in law 20b. Pieca of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/17/99 Havre de Grace, MD Erin Cemetery 22. Name end Address of Fecility 21 Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. there) 123 S. Washington, Havre de Grace, MD 21078 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Approximate Intervei Between Onset and Deeth Immediate Cause (Finel diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 ₩ Unknown 24b. Were autopsy findings aveilable prior to 24a, Wes en autopsy performed? completion of cause of death? 2 No 1 Yes 2 No 1 Yes 26. Plece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28b. Time of

Examiner Weaver, Darrell Rober that the deeth certificeta be executed physician a s the burial-I signed by the a The law requires peed s certificate has b director, page 2 s this After Division Attending deeth. Director: / ŏ hin 24 hours aft the Funeral Di npletaly filled in Hospital

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Examiner

Physician/Medical

by

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Be

Certification: To

Medical

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show trsumstic event, the Medical Example: must be notified at

nd Mental Hygiene. marked other than

end Mental

Health 27

6

Department

Physician /Medical

Important: if item 2 any injury or other once.

the Marylend

With

filed withIn 72 hours after death

Pages 1 and 2 should be

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

5 Pending investigation 6 Could not be

28a. Date of tnjury (Month, Day Year) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

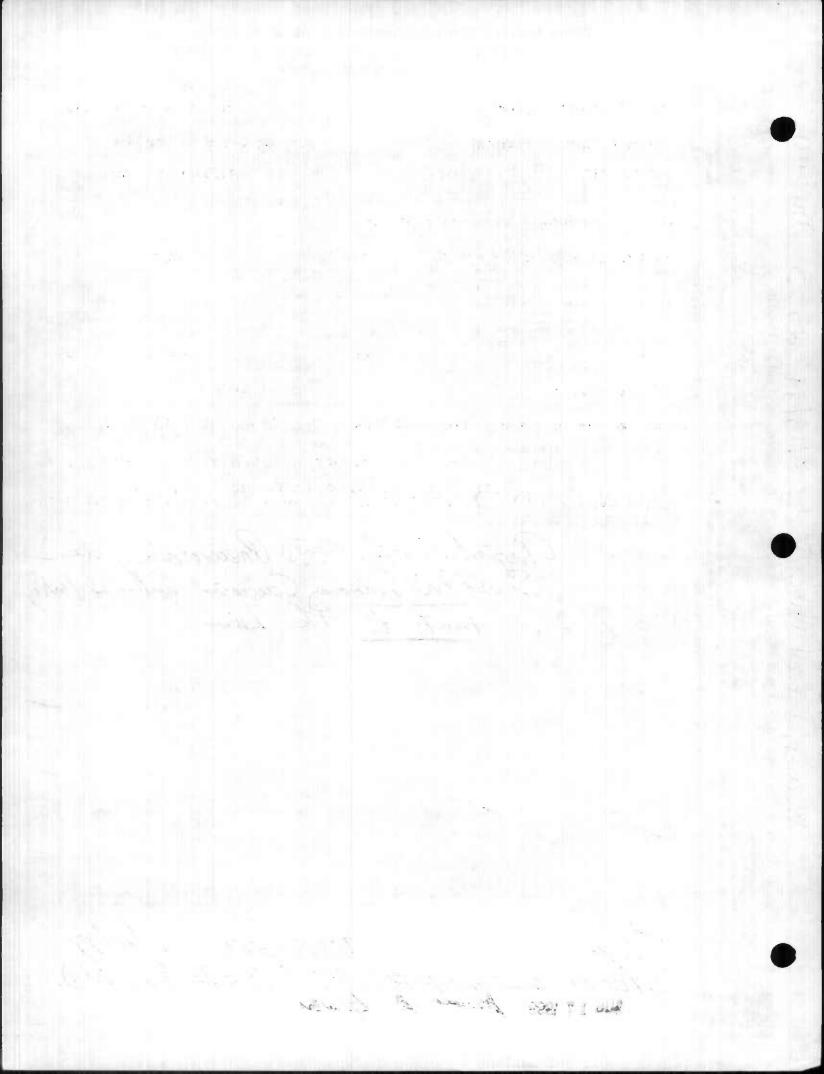
28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and the

29d. Date signed Month, Play, Year)

of person who completed cause of deeth (Item 23a) (Type, Print)

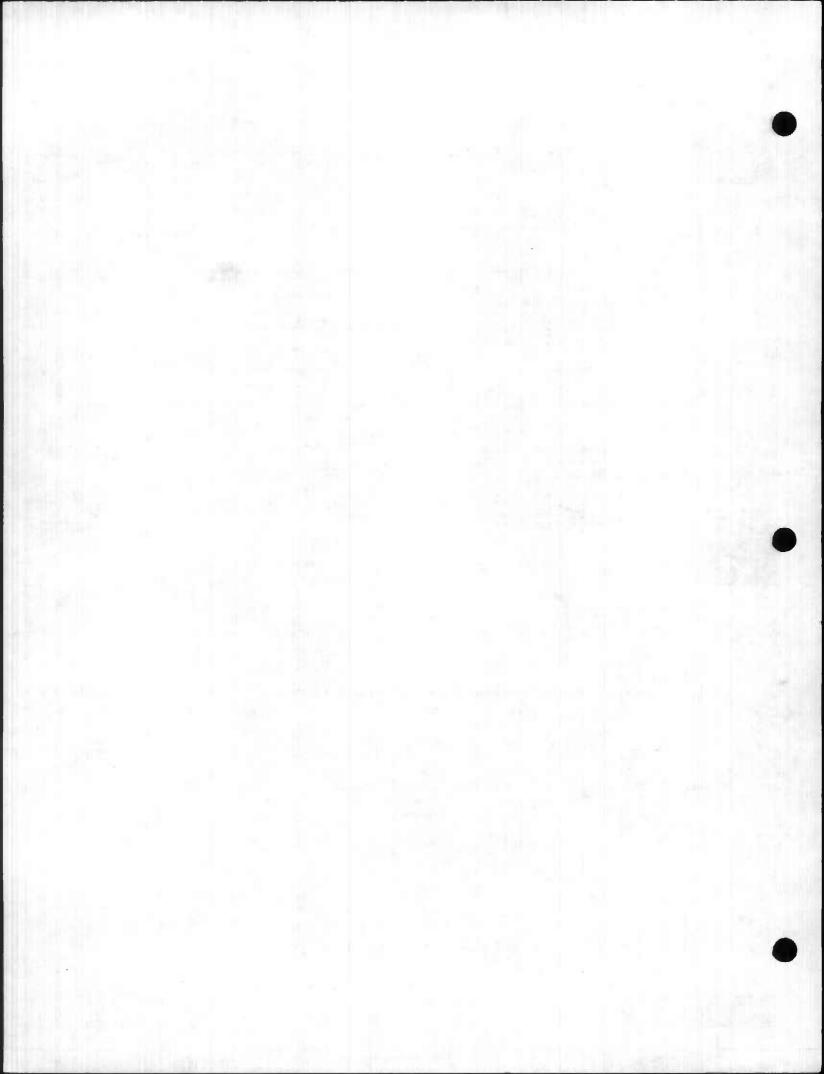
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					Stat	e of M	larylan	-	artmen			ınd M	lental Hy	/giene	E	2	72	75
		1. [Decedent's Name (F	îrst, Middie, L	.ast)								2. Dete of D	eath			3. Tim-	e of Death
	Physician /Medical		Paul (f	Ε.		righ					4h City To		Month August		199		8:	10 AM
A	Examiner		Facility Name (If no			na numbei	7)						cation of Dea			of Death		
7			Casey Hou		Sex	7. A	oe (In vrs.	last birthday) If Under		Rockvi If Under:		8. Date of Bi	rth	T	gome1	9	te or Foreign
	Funeral Director	5	79-50-910	3	1∰M 2[92	Yrs.	Months	Days	Hours	Min.	(Month, D Aug. 1	av. Year)	907	Virg	ginia	te or Foreign
	anyland show sdat			b. County			10c. Cit	y, Town or L	ocation							10	d. Inside	e City Limits
	the Maryland 28a-1 show splifted at ector	V	est irginia	Berkle	у		In	wood								5	1 🗆 Y	es 2 No
	isath with the Maryla re 23s or 28s-f shor mast be notified at eral Director	106	. Street and Numbe						10f. Zip					10g. Cit	izen of V	Vhat Coun	iry?	
	23s Link b	2	22 Tabler	Stati	on Roa	ad					25428			Unit	ed S	State	S	
	0 5 2 5	11.	Marital Status		Am	ed Forces		,S. 13	Was Deced	dent of H cify Cubi	lispanic Orig an, Mexican	pin? (Spo , Puerto	ecify Yes or N Rican, etc.)	0-		e - America k, White, e		•
20	Frank		1 ☐ Never Married 3 ☑ Widowed 4 ☐		lf Ye	Yes 2⊠ es, Give rorDates		1	1□ Yes :	2∰ No	Specify:				Specify	W	hite	
8	filed within 72 hours after Hygiene. ther then "netural", or in int, the Medical Examina or, the Medical Examina or Completed by Fu			Decedent's I		I OI Dates	*	16a Dec	edent's Usua	al Occur	ation			16b. K	ind of Bu	siness/Ind	iustry	
212	led within 72 ho tygiene. her then "neturn nt, the Medical.) Completed	<u></u>	(Specify (only highest g	rade compl		. 5.1	(Giv	e kind of wor DO NOT us	rk done	durina most	of work	ng					
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g	0 2 0 5 6	17.	Father's Name (First	t, Middle, Las	st)						18. Mothe	r's Neme	(First, Middle	e, Maiden	Sumam	Θ)		
yla	ahould b nd Ments merked ametic e		Dorsey L	. Wrig	ht								de L. I					
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altimore,	10 H 0	206	 Method of Disposit Burial 2 □ C 	remation 3		from State	0	emetery, cre	ematory or o	ther pla	∞) Augus	st 21	, 1999			City or To		
븚	rtmon rtant:	-	4 □ Donetion 5 □				Pot						emetery				-	
Ba	Depa Impo any la	21.	Signature of Funer	J /		M	101126	R	ockvil	lle,	Inc.	, 30	0 West 20850	Mont	gome			Home/
	Physician	23	a. Part1. Energy of shock, or heart fa	bease of col	nplications y one cause	that cause on each	ed the deat line.									1		mate Between nd Death
	/Medical	dis	mediate Cause (Fina	di.	. 1	Metas	tatio	Pros	tate (lanc.	er					:	1 Ye	ar
	Examiner		sulting in death)		d			or as a conse		Jane							1 10	<u> </u>
	executed in and ial-transit Examiner				. h													
	and Hran	Se if a	quentially list conditi iny, leeding to imme use. Enter Underlyin	ons,			Due to (o	of as a conse	equence of):									
09	2 25 -		use. Enter Underlyir use (Disease or inju it initieted events	y d	C											i		
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Rox	nding use a				d													
	0 0 2 40	Par	t II. Other significar	t conditions	contributing	to death	but not res	ulting in the	underlying c	ause oiv	ren in Part t.		23b. Dio	tobacco	use cor	ntributs to	the cau	se of death?
0.	law requires that the dea as been signed by the a 2 should be detached f apleted by Physic		Congestiv							3,100			1	Yes 2	No No	3 Prot	ebly	Unknown
	es the	-	Congestiv	е пеаг	t rai.	rure						_						
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Ö	law rias by 2 st	-														of o	death?	of cause
Vitai Records,	Page Corr		Colon Can	cer (r	esect	ed)							10	Yes 2	⊠ No	10	Yes :	2 No
VII 9	ysician: The law lis certificate has I director, page 2 s		Was case referred examiner?	o medical	Magnital					100			(Check only					
0			1 ☐ Yes 2 ☒ No Menner of Death		Hospital:	1 Inpat		ER/Outpatie		_	4LI NU		me 5 Res				Hos	pice
2	ding Phys th. After this funeral di	27.	1 Naturel 5	Pending investigation		Date of Inj (Month, D	ay Year)	28b. Time Injury	M Z	8c. Injui Woi	yat k? Yes 2 □ f	- 1	28d. Describe	now inju	ry occuri	90		
DIVISION	Attending Physician: ar death. ector: After this certific by the funeral director, tification: To Be (☐ Could not	be age	Place of Ir	niury - At ho	ome. farm. s	treet, factory		100 201		28f. Location	(Street ar	nd Numb	er or Rura	l Route I	Jumber,
	XESC E		4 Homicide	determine			elc. (Specif			,			City or To	wn, State	9)			
	To the Hospital or within 24 hours after To the Funeral Dir complately filled in Medical Cert	298	a. Certifier 1 \(\sum_{\text{(Check only one)}}\)	Certifying P Medical Exa	miner: On	o the best the basis manner s	of examina	wledge, dea tion and/or i	th occurred anvestigation,	at the tir	ne, dete and pinion, deet	d place, th occurr	and due to the ed et the time	cause(s) and ma d place, s	nner as st and due to	ated. the cau	se(s)
	within of the omple		. Signature and title	of entifier	1				290	: Licens	e number			29d. Da	te signe	d (Month, i	Day, Yes	ir)
	N		1100	TX	di	Th	Sh	- 14	1	D	37620			A1101	ist 1	18, 1	999	
		30	Name and address	of person who	completed	cause of	death (Item	23a) (Tyne	Print)							, 1		
			ark Godec							anda	le. Vi	irgi	nia 220	003				
	State	_	Date filed (Month, E	ay, Year)		32. Regist	trar's Signa					9.4						
	Registrar		AUG	20 19	99	1 cm	wa	9.	Spo	ak.								

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State of Maryland / Department of Health and Mental Hygiene

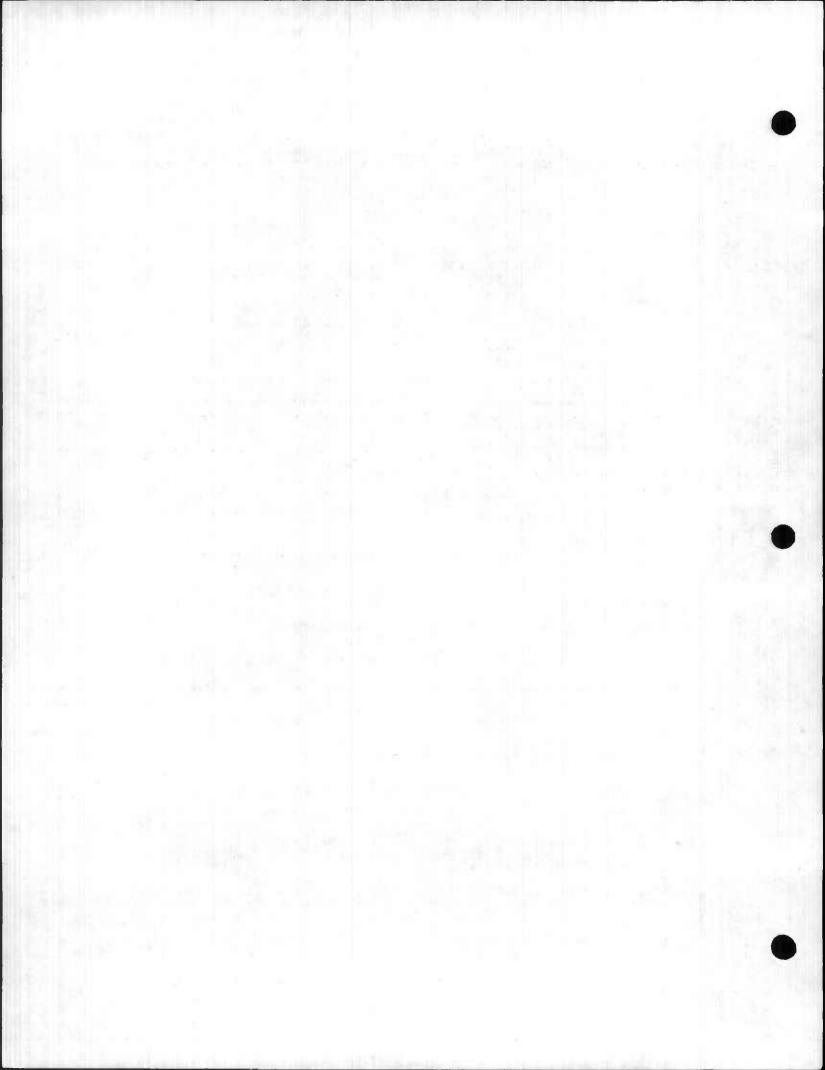
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Ned Wood August 18, 1999 3:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Deys 1 X M 2 □ F Months 220-44-7232 88 Director Sept. 5, 1910 North Carolina Usuai Residence of Decedent the Maryland 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limita worle 7 is marked other than "natural", or items 23s or 28s-f shov traumetic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Montgomery Gaithersburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Russell Avenue #414 20877 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1933 − If Yes, Give Year or Dates: 1954 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 ia marked other than "natural", or ther any Injury or other traumatic evant, the Medical Examina-1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P White 3 Widowed 4 Divorced 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Army 5+ Officer 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Vernon Boy Wood Ella Coble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) William Thompson Wood/Son 3707 Bradley Lane, Chevy Chase, Maryland 20815 20b. Piece of Disposition (Name of cametery, crematory or other place) August 26, 1999
Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removei from State Arlington, 4 ☐ Donation 5 ☐ Other (Specify) Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21 Signature of Funeral 7557 Wisconsin Avenue Bethesda-Chevy Chase, Inc., M01126 Bethesda, Maryland 20814-2501 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** /Medical tmmediate Cause (Final Cerebral vascular Accident days disease or condition resulting in death) Examiner Due to (or as e consequence of): the death certificate be executed physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown Prostate Cancer, Osteoporosis þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No 1 Ves certificate Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: i or Attending P after death. Director: After t 1 Naturai 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30, Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)
P. Callahar A. A. T. Callahar A. Ca +1 Gaithersburg, MD 20879 P. Callahan-Lyon
31. Date filed (Month, Day, Year) 911 Russell 32. Registrar's Signeture State AUG 20 Registrar

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				State of	Maryland		tificate of	lealth and I Death	мептат ну	Reg. No.	27277
Dhuo	alon	Decedent's Nam	e (First, Middla, La	st)					2. Data of Do Month		3. Time of Death
Physi /Mei	dical	Roya1			Wilson	1		4b. City, Town, or L			99 8:49 PM
Exam		4a Facility Nama (f not institution, giv	e street and nun	nber)			4b. City, Town, or L	ocation of Deal	th 4c. County of	Death
Ú.,		F	rederick	Memor	cial Ho	spita	al	Frede			DERICK
Funera	al	5. Social Security N		ex ZM 2□F	7. Aga (In yrs. las		If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di	rth ay, Year)	Birthplace (State or Foreign Country)
Directo	or	149-14-	-02/2	E-M ZLIF	72	Yrs.			Jan.1	2, 1927	New Jersey
20		Usual Residence of	Decedent 10b. County		10c. City, 7	Town or Lo	cetion				10d. Inside City Limits
anyla anyla	*			ما ساء							18 Yes 2 □ No
5 PH	Director	MD	Freder	TCK		rred	erick				
er deeth with the Manyler flerns 23s or 28s-f show ner mast be notified at		10e. Street and Nur	skylar E	Place			10f. Zip Code	0.3		10g. Citizen of Wh	
T 65.3	Te le		,,,, <u> </u>		dent Evar in U.S.	40.1	217		anaita Van an Al	U.S.	A. • - American Indian,
O # 98	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Marned	Armed For	rces? 2 No		Yes, specify Cub	dispanic Origin? (Si an, Mexican, Puarti Specify:	Rican, etc.)	Black,	White, etc. Black
15-002 72 hours	Completed	10	15. Decedent's Ed			16a. Deced	lent's Usual Occup	pation	1.2-	16b. Kind of Busi	iness/Industry
within 7	90	Elementary/Seco	only highest gra	College (1	-4or 5+)	lifa. L	DO NOT use retire	during most of world)	king	D.C. F	ire Dept.
2121 d within giene. or than 'r	E O	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2 yrs	3	Fi	reman				
be filed to there	8	17. Father'a Nama	(First, Middle, Last)					18. Mother's Nan	ne (First, Middle	, Maiden Surname)	
Maryland 2. d 2 should be filed v th end Mentel Hygie 7 Is marked other to	2	Roya	L A. Wi	lson				Leo	la Lew	is	
Aar and le me		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mailin	ng Addrass (Street	and Number or Ru	ral Routa Numb	per, City or Town, St	tate, Zip Code)
Tage		Christo	opher M.	Wilso				lar Pla	ce, Fr	ederick	, MD 21703
		20a. Method of Disp	oosition Cremation 3	Domeral from 6	com	a ol Dispo atary, cren	sition (Name of natory or other pla	ce)	Data	20c. Location - C	ity or Town, Stata
Pag Pag			5 Other (Specify		Me	trop	olitan	F.Serv	3/25/9	Alexand	dria, VA
Baltimore permit. Pages 1 Department of He important: If New eny injury or oth		21. Signaturo of Fu	meral Service Licer	- Lu	ando.	22	SNOWDE	ss of Facility N FUNER LLE, MD	AL HOM 2085		
		23a. Part1. Enter ti shock, or hea	ne prease, or com	plications that cr	used tha daath.	Do not ente					Approximete
Physicia	,	shock, or hea	rt fallure. List only	one cause on a	ach line.						tntarval Between Onset and Death
/Medica		Immediate Cause (Final	Ac	1.4 0 1		144 1000	1'-01	7 1	a la tra	24-48 hors
Examine	r	disease or condition resulting in death)	n	a. FILL	The unt	env	myoca	idial t	rigara	court .	12 17 10 00013
	ě			120	- 00 A day	a a conseq	11000	- Enila	10.0		
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8760, cate be execut physician and the buriel-tran		Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate criying								
68760, ficete be as physicien as the burle	Cal	Cause (Disease or that initiated events resulting in death) I	injury	c	Dua to (or as	s a consequ	fail uence of):	una_			
68 Tillos	Por	resuming in deading	Last				. well				
BOX 6 eath certifit ettending	2			d	occup	-800	, vo dece				1
death certification of for use se	50	Part II. Other signif	icant conditions o	ontributing to de	ath but not rasultir	ng in tha ur	nderlying causa gir	ven in Part I.	23b. Did	tobecco use contr	ribute to the cause of death?
that the dended by the	Physician/M	The state of the							10	Yes 2 No 3	B Probably
strand be de	by F					_					
COTO requir	Completed									s an autopsy omed?	24b. Were autopsy findings available prior to completion of cause of death?
	E								10	Yes MNo	1 Yes 2 No
		25. Was case refar	red to medical					26. Place of Des	th (Check only	one)	
	0	axaminer? 1 ☐ Yes 2⊠	No	Hospital:	npatient 2 EF	VOutpatien	t 3 DOA Ot	nor .		idence 6 Other	(Snecify)
	H	27. Manner of Deat		28a. Date o	finjury 28	3b. Tima of				how injury occurred	
ding Ph th.: Attenti	Ş	Natural 2 Accident	5 Pending invastigation		h, Day Year)	Injury		Yas 2□No			
DIVISION OF Attending after death. Director: After din by the fune	Certification:	3 Suicide	6 Could not be detarmined	286. Piece	ol Injury - At home	a, larm, atr	eet, factory, office				or Rural Routa Number,
D 2425	- Tu	4 Homicide		buildin	ng, etc. (Specify)				City or 10	own, State)	
DIVISION To the Hospital or Attending within 24 hours after deeth. To the Funerel Director: Afte	10	29a. Certifier	1 Certifying Ph	ysician: To tha	best of my knowle	dga, death	occurred at tha ti	ma, data end place	, and due to the	cause(s) and man	ner as stated.
No Ho	edical	(Check only one)	2 Medical Exam	niner: On the ba and mann		and/or inv	astigation, in my	opinion, deeth occu	rred at the time	, date and place, an	nd due to the cause(s)
To the Company	ž	29b. Signature and	titla of certifier				29c. Licens			29d. Data signed	(Month, Day, Year)
3				~	Lon		D	47169		8/18	199
		30. Name and addr	ess of person who	completed cause	of death (Item 23	3a) (Type.	Print)				
			ing Ma		HILLS STORY STORY			e, Bruns	wick.	MD	
s	tate	31. Data filed (Moni	th, Day, Year)	32. ₽€	egistrar's Signatura						
Regis		AU	G 20 199	9 (4)	eperan	Ø.	Sparks				



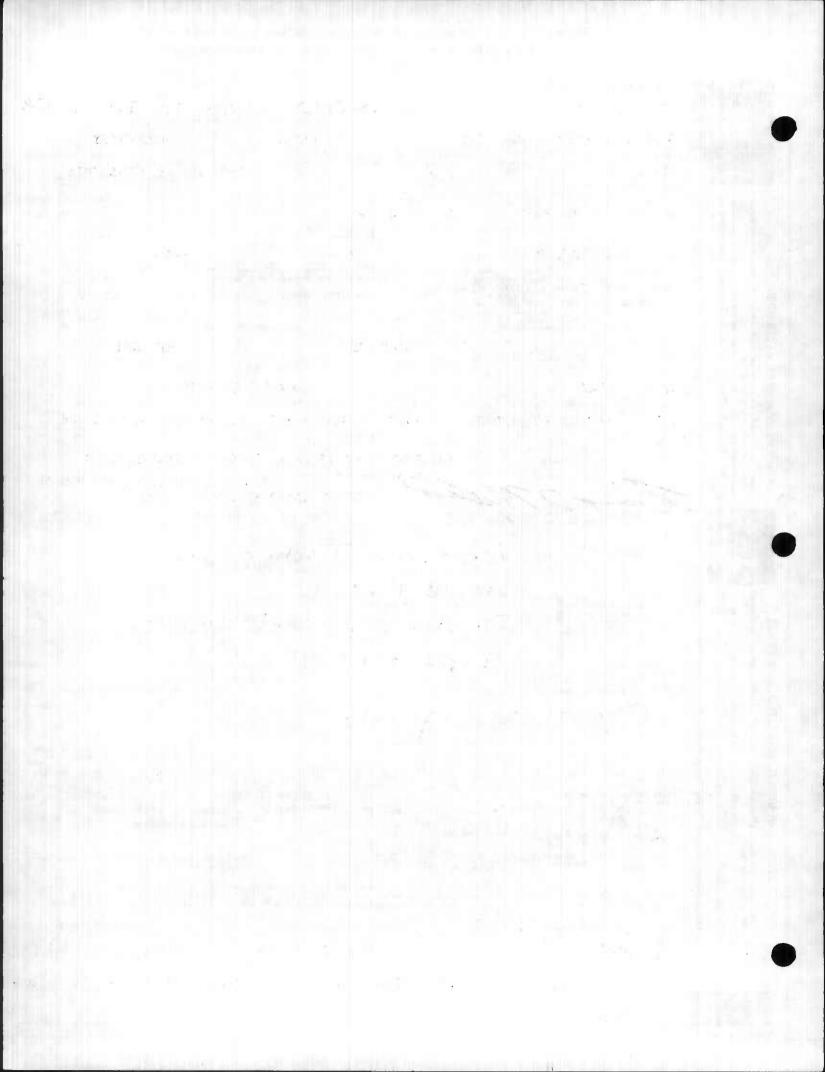
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State of Maryland / Department of Health and Mental Hygiene

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		Certificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)	Mont	of Deeth h Dey Year 3. Time of Death
/Medical			19 13 1999 7:50A
Examiner	4a Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL	4b. City, Town, or Location of	
	5. Social Security Number 6. Sex 7. Age (In yrs. last b	OLNEY	MONTGOMERY
Funeral Director	227-12-8777 1 M 2 F 77	Months Devs Hours Min. (Mont	of Birth (b. Day, Year) 19, 1922 VIRGINIA
Asryland I show ad at	10a. State 10b. County 10c. City, Tox	wn or Location CR SPRING	10d. Inside City Limits 1 ☐ Yes 2 🖔 No
or death with the Maryla thems 23s or 28e-f show the must be notified at uneral Director	10e. Street and Number 15401 BASSETT LANE UNIT 3-C	10f. Zip Code 20906	10g. Citizen of What Country? USA
hor death v r Hems 23a kiner.matt	11. Marital Status 12. Was Decedent Ever In U.S.		
020 ors art exami	Armed Forces? 1 ☐ Never Married 2 ☒ Married If Yes, 2 ☐ ☒ No If Yes, 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 ☐ Yes 2 ☐ No Specify:	c.) Bleck, White, etc. Specify: WHITE
5-0 72 h 72 h 72 h 72 h 64 h	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupetion (Give kind of work done during most of working	16b. Kind of Business/Industry
1 21215-0 led within 72 ho lygiene. Per than fratum nt, the Medical. Completed	Elementery/Secondary (0-12) College (1-4or 5+)	iife. DO NOT use retired) HOME MAKER	OWN HOME
T E 0 1 ()	12 17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, M	
Maryland d 2 should be fits the and Mental hy T is marked oth traumatic event	JESSIE FAGAN	EDNA V. MIDD	
aryla should then market market		b. Mailing Address (Street and Number or Rural Route N	
Mg nd 2 nd 2 strang 27 is grant refrance		5401 BASSETT LANE3-C SILV	ER SPRING, MD 20906
Te a la a de de de de de de de de de de de de de	20a. Method of Disposition 20b. Place	of Disposition (Name of ery, crematory or other place)	20c. Location - City or Town, State
Page ent o mt: If ry or	1 M Burial 2 Cremation 3 Hemovel from State	AWN MEMORIAL PARK 8-16-9	9 ROCKVILLE, MD
Baltimore permit. Pages 1. Department of Hi Important: if ther any injury or oth ence.	21. Signature of Euneral Service Licensee		NALDI 11800 NEW HAMPSHIRE
B god a	2 him 2 Thillies	AVENUE SILVER SPRING	
THE REAL PROPERTY.	23e. Pert1. Enter the disease, or complications Wife caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dylng, such as cardiac or respire	tory arrest, Approximate interval Between
Physician			Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ular Tachycar	dia
UMPER DE LA CONTRACTION DE LA	Due to (of as a	consequence or).	
net net		Failure	
S8760, cate be assected physician and is the burist-transit officel Examiner	if any leading to immediate	consequence of):	22 62 /2
68760, ficate be an sphysician as the buria	cause. Enter Underlying Cause (Disease or Injury that inhibited events)	dependent d	19petes
A 5 04 5	resuring in death) Last		
deam cer deam cer e attendin d for use	d. 179 per	tension	
P.O. Box at the deam cer d by the attendin elached for use Physician/N	Part II. Other eignificant conditions contributing to death but not resulting	In the underlying ceuse given in Pert I. 23b	. Did tobacco use contribute to the cause of death?
hat the de that the de by the detached y Physic	Myasthenia a	Tauls .	1 Yee 3 No 3 Probably 4 Unknown
ds,	Tyasticina q	4015	Oth Warranteen firsteen
Vital Records, sician: The law requires the certificate has been signed rector, page 2 should be by Be Completed by	,	248.	. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
Rec has b pe 2 s mple			of death?
al Re is The is cate ha cate ha Com			1 Yes 2 No 1 Yes 2 No
Of Vital I Physician: The Physician: The Physician: The Physician Physician Physician Physician Physician Physician: The Physician: The Physi	25. Was case referred to medical Hospital: Hospital:	26. Place of Death (Check	
F 4 22 F	112 Inpatient 2 EH/C	Julpatient 3 DOA 4 Nursing none 5	Residence 6 Other (Specify)
On Aling fund for	1 Natural 5 □ Pending (Month, Day Year)	Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	
Division of the or Attending P as after death. at Director, After the funering ind in by the funering Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home,		ntion (Street and Number or Rural Route Number,
Div after Directif	4 Homicide building, etc. (Specify)	City	or Town, State)
Hospi 4 hou Funer laly fill	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, and due to nd/or investigation, in my opinion, death occurred at the	to the cause(s) and manner as steted. time, date end place, and due to the cause(s)
within 2 To the comple	29b. Signature apprilised Carriers	29c. License number	29d. Date signed (Month, Dey, Year)
	1/1/1/1/2	MD 40365	Aug 13 1999
6	30. Name and address of person who completed cause of deeth (Item 23e)		103
			VER SPRING MD 20902
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ /	
Registrar	AUG 1 6 1999	B. sporks	

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** RAYMOND PHILLIP WHITTEN, SR. 11:00 AM 12,1999 **AUGUST** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4901 PENNYROYAL COURT ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year) JULY 13,1937 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 350 28 1946 Director ILLINOIS Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Important: If flam 27 is marked other than "natural", or florms 23s or 28s-1 ahow any injury or other traumatic event, my Medical Examiner must be northing. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. MONTGOMERY ROCKVILLE 1 ☐ Yes 2 No **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4901 PENNYROYAL COURT 20853 UNITED STATES 12. Wes Decedent Ever in U.S. Armed Forces? 1 ∑(Yes 2 □ No 1959 = If Yes, Give Year or Dates: 1968 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☑ Married 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 PROGRAM MANAGER SPACE INDUSTRY Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 ROBERT HAROLD WHITTEN, SR. VIRGINIA CHARLOTTE HOMAN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4901 PENNYROYAL COURT, ROCKVILLE, MD. 20853 PATRICIA L. WHITTEN, WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State METROPOLITAN CREMATORY 8/13/99 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee MURIEL Adjess of Facility ER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, tock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** /Medical Immediate Cause (Finet metastatic leiomyesarcoma 3 years disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 2 Due to (or es a consequence of): signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to Completed 24a. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No al or Attanding Physician: To after death.
If Director: After this certificated in by the funeral director, p 25. Was case referred to medicat examiner? 8 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completely lilled in by the Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number a Sytromo D43083

20+1

Box 68760.

Division of Vital Records. P.O.

Registrar

31. Date filed (Month, Day, Year) AUG 16 1999

9707 Medica

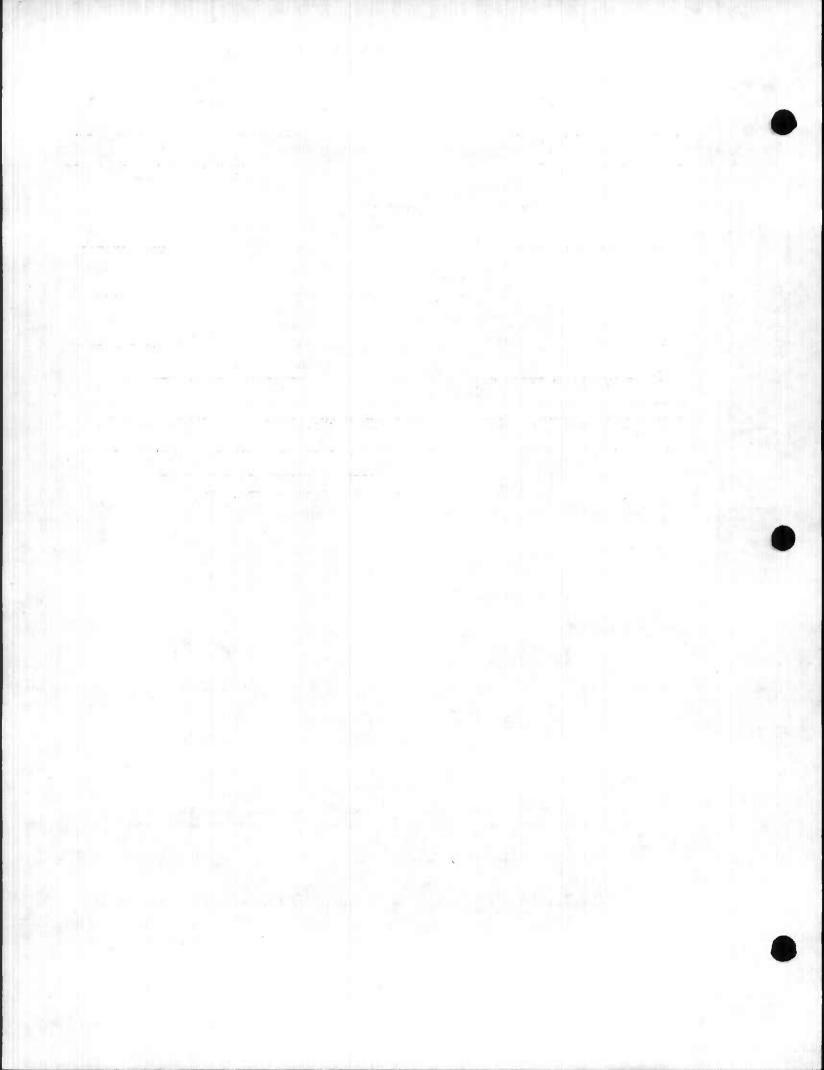


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rochville, MD 20850

AUGUST 12,1999

George A. Sotos, MP.



State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23B PER MD G775 9-18-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12:17PM **Physician** REGINALD WHITE 8 12 - /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Takoma Park

If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Yeer) Washington Adventist Hospital 9. Birthplece (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) **Funeral** 1☑M 2□F Months Days Yrs. Director 218-38-8993 Usual Residence of Decedent Oct. 3, 1943 Kansas permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 € No Directo Maryland | Prince George's Beltsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 4202 Ulster Road 20705 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 t. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Limousine Service 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Roland H. White Lorraine Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4202 Ulster Road Beltsville, Maryland Mary S. White (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 8/16/99 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. Ken Skile 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart fellure. List only one cause on each line. 20901 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final SUDDEN WEATH WITH FIBRILLATION 15 min. CARDIAC disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine GENERALIZED ATHEROSCLEROSIS YEARS that the daath certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es e consequence of) HEARS Division of Vital Records, P.O. Box 68760, DIADETES MELLITUS Physician/Medical Due to (or as a consequence of) RENAL YEARS FAILURE USB signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Ves 2 No 3 Probably 4 Unknown HYPERTENSION p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? HYPERLIPIDEMIA hes 1 ☐ Yes 2 No 1 ☐ Yes 2 No TOE G-ANGRENE 25. Was cese referred to medicel examiner? 28. Place of Death (Check only one) Be Hospitel: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of After or Attending 1 Natural 5 Pending 24 hours after death. Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital Territying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completaly f (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 8-12-99 Grown MD PhD D36784 10 AVE, 57E. 300 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 7610 CARROLL R. BROWN MD PhD PARK 20912 TAKOMA DIVAC 31. Date filed (Month, Dey, Yeer) AUG 1 6 32. Registrar's Signature State eneva Registrar

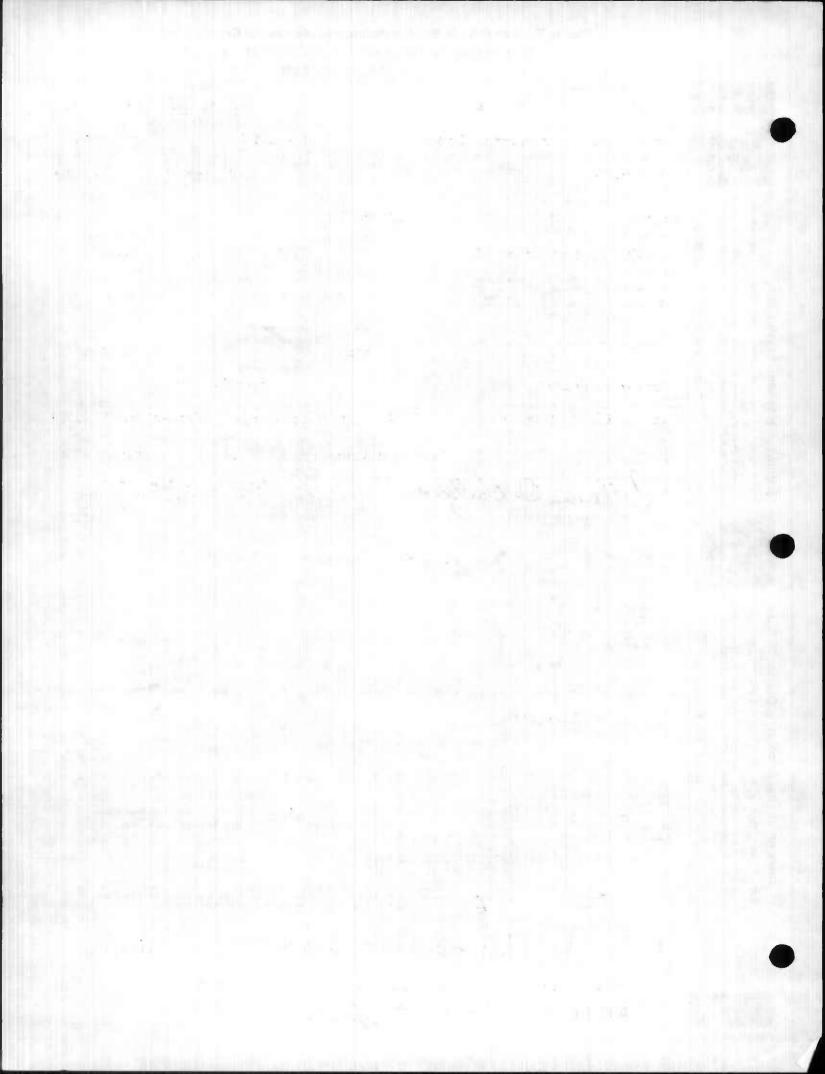
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 12" 1999 August Vadie Wedd1e 11:05AM Helen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Frederick Northampton Manor Nursing Center Frederick If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) July 24, 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Deys Hours 1 □ M 2 K F 89 Maryland Yrs. 220-28-2758 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. If Input and Mentel Hygiene important: If Itam 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other traumatic event, my Medical Example manufactures. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Frederick Frederick Maryland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 U.S.A. 21701 7909 Chestnut Grove Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 11. Marifal Stafus 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: þ SpecifyWhite 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) restaurant cook 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Harvey P. Conner Blanche Green 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Marie E. Flohr/ daughter 7909 Chestnut Grove Rd. Frederick, MD 21701 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burlei 2 ☐ Cremetion 3 ☐ Removel from Stete 8/14/99 Libertytown, MD Fairmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Funeral Servica Licanse Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway 23a. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each inner. Approximate fntervel Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical YEARS ARTERIOSCURETIC CARDIOUASCUAR DISCHASE **Examiner** Due to (or es e consequence of): Examiner attanding physician and for use es the bunel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lesf Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significent conditions confributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No DIABSTES ò 24b. Were autopsy findings aveileble prior to completion of cause of death? should t 24e. Wes en eutopsy performed? Completed certificate has b lirector, page 2 s 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 30 No Other: 4 Sursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident Director: A 6 Could nof be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide thin 24 hours after the Funeral Dire impletaly filled in b Cardifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and manner es steted.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signeture end title at an W 29c. License number mo D35111 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) WALKORSUILLE RICUARD L. GOUEN 328 MD 21793 PO BOX 31. Date filed (Month, Day, Year) 32. Registrer's Signature State AUG 1 6 1999

Registrar



	Pieas	e Type or State o	Print in E of Marylan								200	2	7202	
				Ce	rtificat	e of	Death			Reg. No.				
	Decedent's Name (First, Middle, L	Last)							2. Date of De				3. Tima of Death	Ī
n al	Emma Ruth Walls								Month August	Day	1999		12:30 am	
ai er	4a. Facility Name (If not institution, g	riva street and nu	ımber)				4b. City, To	own, or Lo	ocation of Deat		County of De	ath	12.30 911	-
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		. Sex	7. Aga (In yrs. i	last birthday)	If Undar	1 Yaar	If Under		8. Data of Bi	rth		_	ca /Stete or Foreign	,
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	10a. State 10b. County		10c. City	, Town or Lo	ocation							100	d. Inside City Limits	
io	Maryland Caroli	ne		Hen	nderso	n							1 ☐ Yes 2 ☐ No	
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era	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Deced			iain? (Sp	ecify Yas or No		14. Raca - An	nericar	Indian.	-
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ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	va		1 Yas	2XI No	Specify:				Specify:	Th d +		
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Completed by Funeral Director	(Specify only highest g	rede completed)		(Give	kind of wor DO NOT us	rk done se retire	during mos	st of work	ing					
E	Elementary/Secondery (0-12)	College (1-40[5+)		ment					Di	xon Va	lve		
C e	17. Father'a Neme (First, Middle, Las	st)							e (First, Middle	-		_ , _		
0	Harvey Ivins						Maz	ie O	uillen					
-	19a. Informent's Name/Relationship	(Type, Print)		19b. Mailie	na Address	(Street			al Route Numb	er. City of	Town State	Zio C	ode)	_
		andson			340 He				Hender				21640	
	20a. Method of Disposition	andson	20b. P	ace of Dispo	osition (Nen	ne of		Nu	Date		cation - City			
	1 Buriai 2 ☐ Cremation 3		State	emetery, crei	metory or o	ther ple		1	255					
	4 □ Donation 5 □ Other (Spec		Gre	ensbo					3-22-99	Gree	ensbor	0, 1	Maryland	
	21. Signature of Funeral Service Lica	ansee	,	22	2. Nama an	d Addre	ss of Facili	ty on ho	in Fune	rol i	Uomo			
	Much	11	ugh		O Box) G	reen.	sboro,	Marv	land	21	639	
	23a. Part1. Enter ha disease, or con shock, or heart failure. List ont	mplications that	caused the death	. Do not ent	ter the mod	e of dyir	ng, such as	cardiac	or raspiratory a	rrest,		A	oproximata interval Between	ı
ı													Onset and Death	
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	resulting in deeth)	е.		es e consec	quence of:	- 1	1.70	1					. 10 21 3	H
Examiner		A	nasar									1	march	
	Sequentially list conditions.	b	Due to (or	as a consec	quence of):							-	.1.0/11/1	i
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		Pancre			A 10. 4	2.0					L	magle.	
2	Cause (Disease or Injury that initiated events	с		as a conseq		41/6	er					1	סאון אָכתו	_
completed by Physician/Medical	resulting In death) Last				- *							i		
1100		d										<u> </u>		
2	Part II. Other significant conditions	contribution to d	eath but not resu	liting in the u	inderlying o	ause oi	en in Pert		23h Did	tobacco	use contribu	ris to t	he cause of death?	_
2										Yes 2		Proba		
7	GCI-D, C	olon.	allenor	ma,	NTN	J	750	CAL	, "	9	due on	11000	bry 4 diminor	
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200	Dreast due	t hun	erplo	7	10	10	este	10%	perf	ormad?		comp	able prior to pletion of cause	
-		l'										of de	eth?	
3									10	Yes 2	No	10'	Yes 25 No	
3	25. Wes case referred to medical examiner?	Hospital:				Ott	or		h (Check only					
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	27. Menner of Death Seturel 5 Pending		of Injury th, Dey Year)	28b. Time of Injury		Bc. Injur Wor			28d. Describe	now injury	y occurred			
	2 Accident investigation 3 Suicide 6 Could not	he			М		Yes 2□	-						
	4 Homicide determined	d 286. Placa	of Injury - At ho ing, etc. (Specify	me, farm, str	raet, factory	, office			28f. Location (City or To			Rural F	Route Number,	
3														
	29a. Certifier Certifying P													
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3	29b. Signatura and title of certifier						a number	400		29d. Date	a signed (Mo			
		1	MD			05	113	5		81	201	99		
ł	30. Name and address of person who	completed cau	e of death (Item	23a) (Type,			•							

6602 Church Hill RD

sparks

32. Registrar's Signature

Chestertown, MD 21620

State Registrar

Frederick Delboy MD

31. Date filed (Month, Pay, Year) AUG 2 0 1959

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Haalth end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, if a Modical Evantine, must be notified at ORGS.

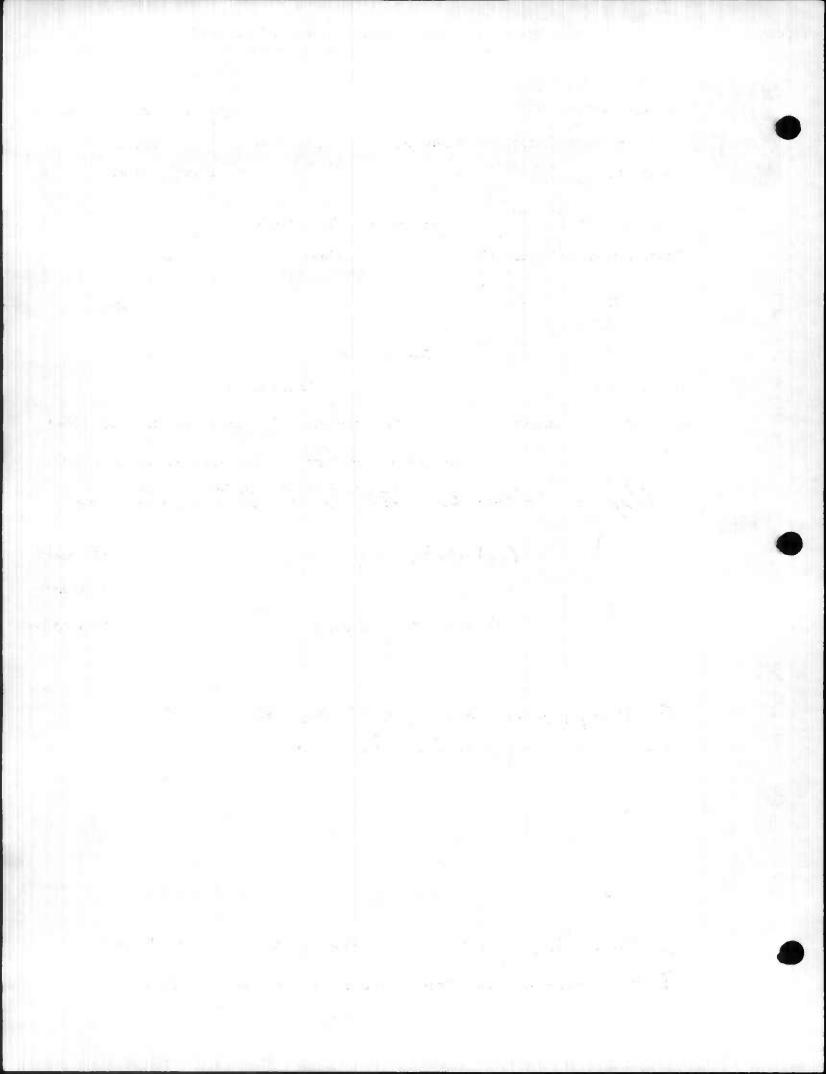
Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be datached for use es the bunal-transit

Division of Vital Records, P.O. Box 68760,

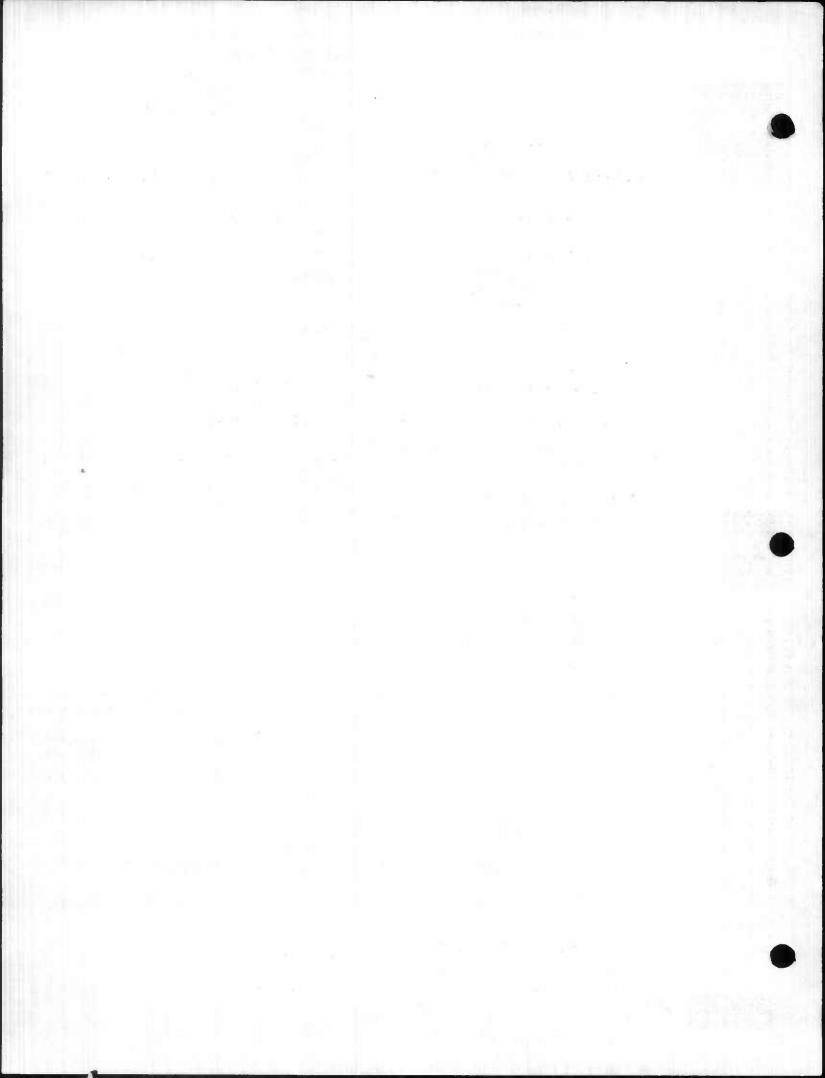
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			•	Cert	ificate of i	Death		Reg. No.	61403
	Dharis		Decedent's Neme (First, Middle, Last)		* **		2. Dete of De Month		3. Time if the
	Physici /Medi		BLANCHE L.	. WYA	IT			8, 199	9:22 PM
	Examir		4e. Fecllity Neme (If not Institution, give street and number)		4	b. City, Town, or			
			Caroline Nursing Home			Dento			roline
	Funeral Director		5. Sociel Security Number 215-18-4567 G. Sex 1 M 2/C) 7. Age (In yrs. le. 1 M 2/C) 7. Age (In yrs. l		If Under 1 Year Months Deys	If Under 24 Hrs Hours Min.	8. Dete of Bird (Month, De Jul. 2	th y, Year) 1,1915	9. Birthplece (State or Foreign Country) Delaware
	land w			Town or Loca	ition				10d. Inside City Limits
	Mary	to	MD Caroline			Den	ton		1 ∑ Yes 2 □ No
	or 284	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Country?
	23a d	ral	520 Kerr Avenue		2	21629		United	States
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "hattoral Exam on must be notified at 2016.	by Funeral	11. Meritel Stetus 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yeer or Detes:			ispenic Origin? (S en, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Rece Blec Specify	e - American Indian, sk, White, etc. White
5-0	2 should be filed within 72 hours end Mental Hygiene. Is marked other than "natural", aumatic event, the Madical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usuel Occup	ation during most of wo	rkina	16b. Kind of Bu	usiness/industry
121	Ne vithin	Мф	Elementery/Secondary (0-12) College (1-4or 5+)			during most of wo		Own 1	lomo
	fled v flygie flor t	ပိ	6 17. Fether's Name (First, Middle, Last)	110 m	emaker	19 Mother's Nov	ne (First, Middle,		
Maryland	od be	Be	George Thomas Care	V			Lee Co		6)
2	should and Me mark imatic	မ	19a. Informant's Neme/Reletionship (Type, Print)	•	Address (Street	and Number or Re			State 7in Code)
S	od 2 s lift er 27 ls		Elsie Jones/Sister			166, L			
Je,	A Head		20e. Method of Disposition 20b. Pie	ace of Disposit	tion (Neme of tory or other plea	ve1	Date	20c. Location -	City or Town, Stete
E	Page nent o nt: If iry or		1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) C O	kesbu	ry Ceme	etery	8/20	Reliar	nce, Maryland
Baltimore	permit. Departminity of the permit of the pe		21. Signeture of Funerel Service Licensee	22. N	Neme end Addres	ss of Fecility - Hawkin	s-Esko	w Funer	ral Home, PA
	-53709		23e. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart fallure. List only one cause on each line.	P 0	Box 43	B, Fede	ralsbu!	rg, MD	21532 Approximate
-0	Physician		shock, or heart fallure. List only one cause on each line.		•			·	Interval Between Onset and Deeth
4	/Medical		Immediate Cause (Finel disease or condition resulting In deeth)	52.0	1	Lia E	154		Sun
п	Examiner			es a conseque		T'14 - C		37	340
	p ti	luei	a b						
	death certificate be executed e attending physicien and od for use as the bunel-transit	Examiner	Sequentially list conditions, if any, leading to immediate	es e conseque	ence of):				
68760,	be e purie		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury						
687	rtificate ng phys	Medical	that Initiated events resulting In death) Lest Due to (or e	es a conseque	ince of):				
Box	nding use a		d						1
	death ce attendir d for use	icla	Part II. Other significant conditions contributing to death but not resulti	ting in the und	edular cause rive	on in Bort I	22h Did	lahanna usa nar	ntribute to the causs of death?
P.0	by th	Physiclan/			13.9				3 □ Probably 4 ☑ Unknown
Ś		by F	Atrial Fibrillation, D) cabe to	es vacili	tus			
Record	requii	Completed						an eutopsy med?	24b. Were eutopsy findings available prior to completion of cause of death?
A.	The law are has bege 2 st	Eo					101	res 22 No	1 ☐ Yes 2 ☐ No
of Vital		Bec	25. Wes case referred to medical examiner?			28. Plece of Dec	eth (Check only o	ne)	
Ž	Physician: this cartific ral director,	2	Hospitel:	R/Outpatient	3□ DOA Oth	er: Nursing H	ome 5 Resid	dence 6 Othe	er (Specify)
	ng P	on:	27. Manner of Deeth 28e. Date of Injury 1. Neture 5 ☐ Pending (Month, Dey Year) 2	28b. Time of Injury	28c. Injury Work		28d. Describe I	now Injury occurr	ed
Division	tendi seath. tor: A the fu	Certification:	2 ☐ Accident Investigation			Yes 2 □ No			
Σ	or At or At Direct in by	Prtiff	4 Homicide determined 28e. Piece of Injury - At hom building, etc. (Specify)	ie, ferm, street	t, fectory, office		28f. Location (S City or Tox		er or Rural Route Number,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical Co	29a. Certifiler (Check only Certifying Physician: To the best of my knowled	ledge, deeth o	ccurred at the tim	ne, dete end pleca	, and due to the	cause(s) and me	nner as stated.
	the the mplet	Med	29b. Signature and title of pagifier		29c, License				d (Month, Day, Year)
	5 2 E 8	-	Her / to					/ _	Landing Day, 1001)
		-	20 Name and address of passes when	00-1 (T T		7492		8/20	199
			30. Name and address of person who completed cause of deeth (Item 2	:sa) (Type, Pri	one)	27 6	oldsbon	MIN	54.34
	Sta	te	31. Pate filed (Month, Day, Year) 32. Registrer's Stynetur	ire ,	1007	ad the	0000000	WI) 60.4 36
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State of Maryland / Department of Health and Mental Hygiene

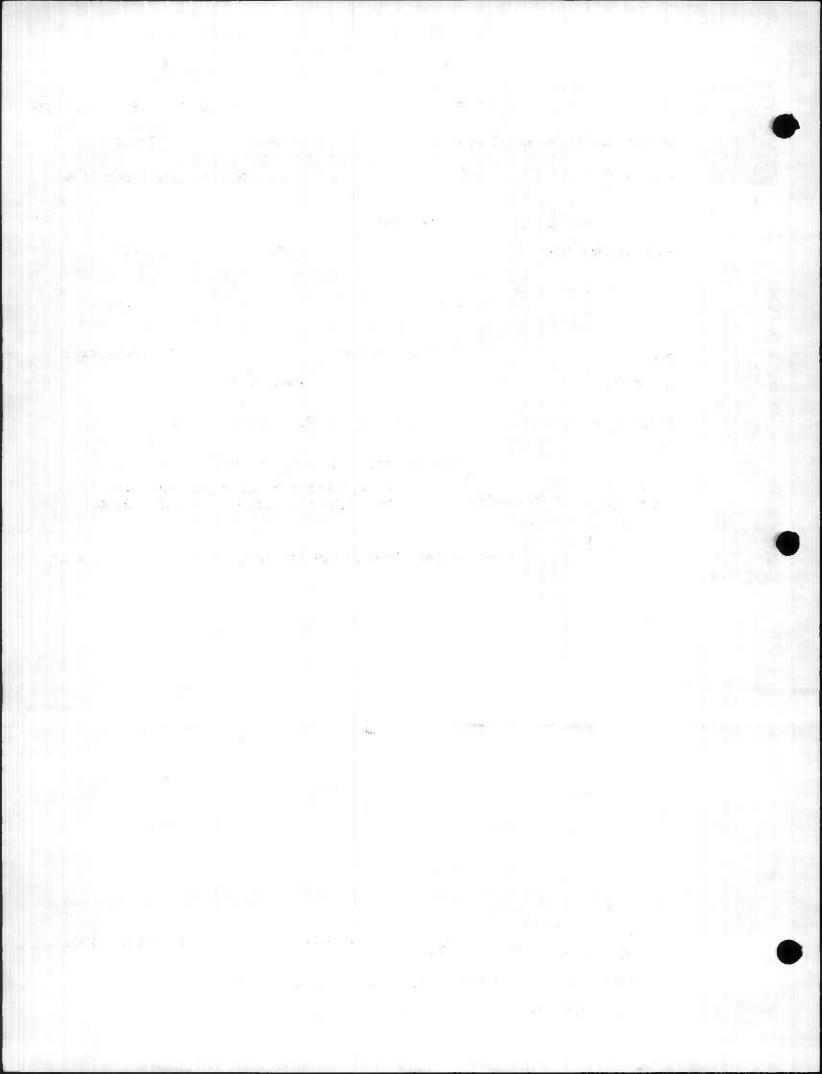
				Otato of Marylan		ate of Death		leg. No.	2	7204
			1. Decedent'a Name (First, Middle, La	st)	1 \		2. Date of Dee Month		Year	3. Time of Death
	Physici /Medic		Derek LAI	nont W	latson		8	19 1	999	(000 pm
	Examin	er	4a Fecility Neme (If not Institution, giv	e street and number)	Lasnita	4b. City, Town, o	or Location of Death	Oc. County	0	onmes
	E		5. Social Security Number 6. S	tky lung [7]	last birthday) If Und	der 1 Year If Under 24 H	rs. 8. Date of Birth	princ		COTY CO
	Funeral Director		Usuai Residence of Decedent	AM 2□F	Yrs. Month	Days Hours M		Year) 99	Coynth	5.
	how	271	10e. Stete 10b. County	10c. Cit	y, Town or Location				100	d. fnside City Limits
	e Ma	Funeral Director	M.D. Prince	beorges (heltenn	am				1 Yea 2 □ No
	vith th	Dire	10e. Street and Number	10/100 Dul	101.	Zip Code	1	Og. Citizen of V	Vhet Country	y?
	eath	erai	11. Maritai Status	12. Wes Decedent Ever in U.	S. 13. Was Dec	cedent of Hispanic Orlgin?	(Specify Yes or No-	14. Rac	e - Americar	n Indien,
0	w Ren	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		pecify Cuben, Mexican, Pu	erto Rican, etc.)		ck, White, et	c.
005	raf', o	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		2 No Specify:		Specify	bla	CK
21215-0020	be filed within 72 hours after death with the Maryland (al Hygiene.) d other than "natural", or items 23a or 23s-1 show event, tra Medical Examiner mast be northed as	Completed	15. Decedent's Ed (Specify only highest gra	fucation ide com <i>pleted)</i>	16a. Decedent's U: (Give kind of	sual Occupation work done during most of w use retired)	vorking	16b. Kind of Bu	usiness/Indu	stry
212	withle ene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Me. DO NO	none			SIA	
	il Hygi other	Be C	17. Father's Name (First, Middle, Last)				lame (First, Middle,	Malden Suman	ne)	4
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be nomited.	To	Dary 1 Veri	ion Wat	50n	Ivey	Renee	Davis	W	atson
Mar	2 sho and Is me		19a. Informent's Name/Relationship (/	19b. Meiling Addre	ess (Street and Number or	Aural Route Numbe	11 1		
	1 and Health em 27 other tr		TUEY W4150A 20a. Method of Disposition	1 / mother	Piace of Disposition (#	Vame of	Pue. Che	17enhar 20c. Location -		D 20623
nor	Pages nent of I mt: If ite iry or or		1 Buriel 2 Cremation 3 4 Donation 5 Other (Specif	JHemovel from State	cametery, crematory of	r other place)			,	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service Licer		22. Name	and Address of Facility				
Ö	Ped F #		Amount 11	aprese.	CA	re An AT	my Bo	BA	45 1	412
	100	1	Part1. Enter the disease, or comhock, or heart failure. List only	plications that caused the deat	h. Do not enter the m	ode of dying, such as card	liac or respiratory are	rest,	11	Approximete Interval Batwaen
d	Physician		and the same of	7		+-(1		rales) (Onset and Death
7	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in deeth)	a	reune	ry less 1	thm do	200 CS	./	
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	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions,	b Due to (c	or as a consequence of	of):				
60,	be exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C					i	
68760,	g phys	edical	thet initiated events resulting in death) Last	Due to (o	r as e consequenca o	f):			1	
Box	attending for use a	Approx.		d					1	
	the atte	Physician/N	Part II. Other significant conditions of	ontributing to death but not res	uiting in the underlyin	g cause given in Part f.	23b. Dfd t	obacco uae co	ntribute to t	the cause of death?
P.0	ta of						101	* 2 No	3 Probe	ably 4 Unknown
ds,	signed d be de	d by					24a. Wes	an autoney	24h. Wer	re autopsy findings
Records,	v require been si should I	ete					perfor	med?	evai	ilable prior to ppletion of cause eath?
Re	The law ate has page 2:	Completed					1 🗆 Y	es 2 No		Yes 2D-N6
Vital		BeC	25. Was case referred to medical			26. Place of D	Deeth (Check only or		1 .0	100 22.10
of V	5 00 0	ToE	examiner? 1 Yes 2 No	Hospitei: 1 Inpatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Resid	enca 6 □Oth	er (Specify)	
n o	ding Pi h. After th funera		27. Menner of Death 1 ☑ Netural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe h	ow injury occur	red	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b	9 See Siere of triver At h	M ome farm street fact	1 Yea 2 No	28f. Location (S	treet and Numb	per or Rural	Route Number,
Ď	after after Direction b	ertii	4 ☐ Homicide determined	building, etc. (Specif		ory, onloo	City or Tow			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of exemina	wiedge, death occurre	ed at the time, date and pla	ace, and due to the	cause(s) and ma	anner as sta	ited.
	the Ho in 24 the Fu	ledical	4	and menner stated.						
	To To	×	29b. Signature and tale of certifier		5	29c. License number D 3430		29d. Date signe		
			Herry	an m.	0000 /7000 7000					,
			30. Name and address of person who	completed cause of death (item	n ∠3a) (Type, Print) CA M~_	8 : 7503 S	MERATT	RD	0111	1700 mD
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature &	- 103		1 122	CLIN	1010,1112
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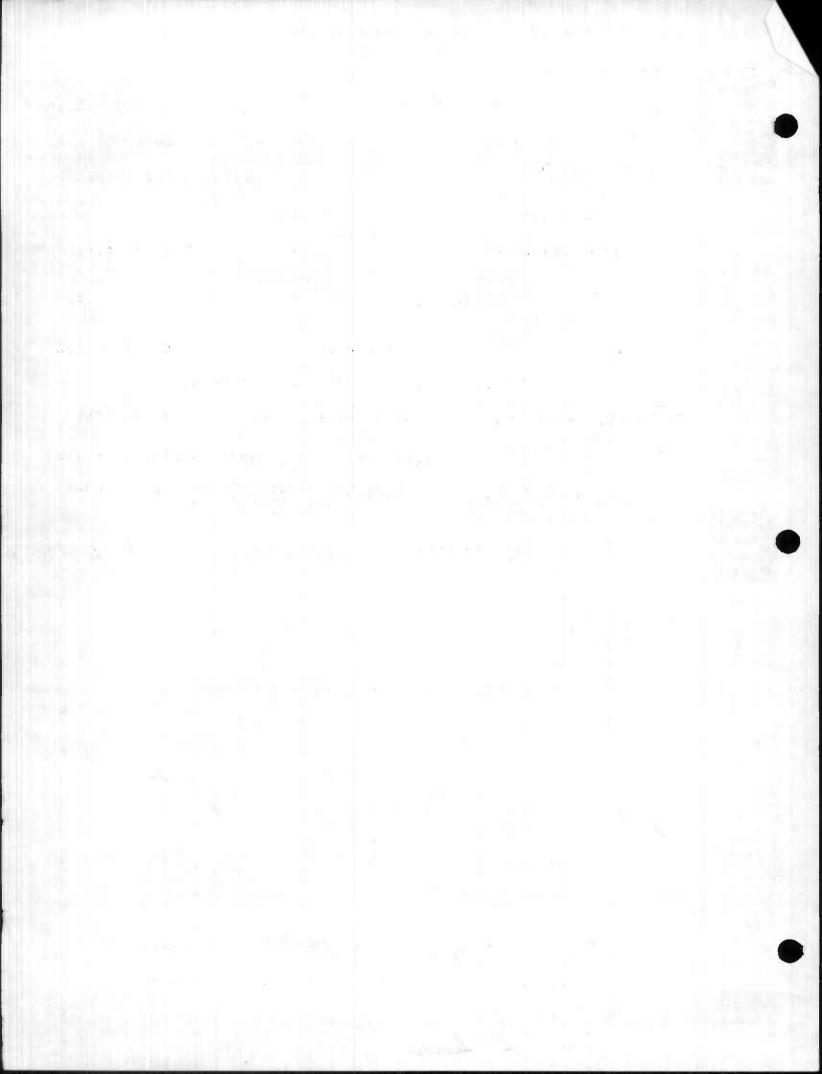
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State of Maryland / Department of Health and Mental Hygiene

							Ce	ertificate o			Re	eg. No.	14.1	SE-10.30
	Physic	an	1. Decedent's Neme	First, Middle, L							2. Dete of Deet Month	h Dey	Year	3. Time of Death
	/Medi		Ervin	(NMI)	Yu	tzy					August	12, 19		4:34 PM
	Examir	ner	4e. Fecility Name (If	not institution, gi	ve street end numb	er)			4b. City, To	own, or Loc	cation of Death	4c. County	of Death	
L					Memorial					land		1	rrett	
	Funeral Director		5. Sociel Security No. 216–22–5 Usuel Residence of	5526	Sex 7. 1 M 2 □ F	Aga (In yrs. 72	last birthday Yrs.	Months Dev			8. Dete of Birth (Month, Dey, Sept 5,			olece (Stete or Foreign otry) yland
	anyland show	2	10a. Stete	10b. County		10c. Cit	y, Town or L						1	0d. Inside City Limits 1 ☐ Yes 2€ No
	the N	ect	MD 10e, Street end Num	Garret	t		Swant						10.0	
	ath with 23a or	Funeral Director		y Run Ro	ad			10f. Zip Code	215			0g. Citizen of	USA	itry?
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at ance.	by Fune	11. Merital Status 1 □ Never Merric 3 □ Widowed	ed 2 Married	12. Was Decede Armed Force 1 X Yes 2 If Yea, Give Year or Dete	ns? □ No		Was Decedent of If Yes, specify C			cify Yes or No- Rican, etc.)		e - Americ ck, White, v: whit	atc.
ō	2 hou			15. Decedent's E	ducation		(edent's Usuei Occ	cupation			16b. Kind of B		
2	hin 7	Completed	(Speci	ify only highast gr	ade completed) College (1-4)	or 54)	(Giv	edent's Usuei Occ e <i>kind of work doi</i> DO NOT use ret	ne during mos ired)	st of workin	g			
	d wit	MO.	8 th	loury (0-12)	Conege (1-4	51 34)	Truck	Driver				Trans	porta	ation
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ary	shou Ind N	-	19e. Informent's Ne	me/Reletionship	(Type, Print)		19b. Mei	ing Address (Stre	et end Numb	er or Rurai	Route Number,	City or Town,	Stete, Zip	Code)
	alth a 27 ls		Agnes V	. Yutzy/	wife		1211	Dry Rur	Rd.,	Swant	ton, MD	21561		
ore	of He of He item		20e. Method of Disp		70		Place of Disp	osition (Neme of	olece)		Dete 2	20c. Location	City or To	wn, Steta
Ĕ	Pages 1 and 2 nent of Health ant: If item 27 Is ury or other tra			☐ Other (Speci	Ramoval from Sta	ite		tn. Cem.		16.	1999	Accide	nt. N	MD
Baltimore,	permit. Departn Imports any Inju		21. Signeture of Fur	neral Service Lice	nsee	1	2	2. Nama and Add	dress of Fecili	ity				
00	88 = 88		100	(m. 1)	homa	,)		ewman Fu						_
			23e. Pert1. Enter the shock, or team	n dinease, or con	nplications that cau	sed the deat	h. Do not er	79 Mille	tying, such es	cardiac or	r respiretory erre	est,	21536	Approximete
	Physician		snock, or man	List only	one ceuse on eec	n line.							1	Onset end Death
/	/Medical		Immedieta Ceuse (I	Final	91.40		1	- 0	North	T	2			orden and a second
	Examiner		diseese or condition resulting in death)	1	e. Arte		Leroti or es e conse	c Corona	ary Art	ery I	Disease	-	P	Minutes
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	tificate be executed ig physician and es the bunal-transit	edicai Examiner	Sequentially list con	ditions	b. —	Due to (o	or es e conse	quence of):					1	
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0	es that the death cer igned by the attendir be deteched for use	Physician/M	Pert II. Other eignific	cant conditions	contributing to deat	h but not res	ulting In the	underlying cause	given In Pert	l.	23b. Did to	bacco uee co	ntribute to	tha cause of death?
<u>Ч</u>	at the	Phy									1 □ Y	s 2 No	3 ☐ Prol	bably 4 Unknown
Ś	es the	by	_											
Record	The law requires that the death ate has been signed by the atter page 2 should be deteched for t	Completed	_								24e. Wes er perform	n eutopsy ned?	ev	ere autopsy findings eilebie prior to mplation of causa
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											1 ☐ Ye		1[Yea 2□ No
5	ysician: is certific director,	Be C	25. Wes case referrence exeminer?		Hospitel:				Othor		(Check only on	125		
o	Phy this	. To	1 X Yes 2 ☐ t 27. Manner of Deeth		1 ∐ inp	atient 2	28b. Time	HIL SEE DOA	4014	-	ne 5 Reside			k)
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S	Attending ar death. ector: After by the fune	fica	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not b	oe Diese of	Injury - At ho	ome ferm s	treet, factory, offic			8f. Location (St.	reet end Numl	oer or Rure	I Route Number,
2	Olre Dire	Certification:	4 Homicide	determined	building,	etc. (Specif	y)	aroot, ractory, onn			City or Town			, , , , , , , , , , , , , , , , , , , ,
	ours ours filler		29a, Certifier	1□ Certifying Pi	hyaician: To the be	st of my kno	wledge dee	th occurred at the	time dete en	nd niece a	nd due to the ce	use(s) and m	nner ea ei	tated
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical		2⊠ Medicai Exe	miner: On the besis	of exemine	tion end/or in	nvestigetion, in m	y opinion, dee	oth occurre	d et the tima, de	ate and place,	end due to	the ceuse(s)
	of the	Me	29b. Signetura end I	title of certifier				29c. Lice	ensa number		29	9d. Date signe	d (Month,	Dey, Year)
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MENI	D ITEM: #	19B	PER INFORMANT G775 9-1	State of Ma	rylan			nt of H te of L		nd Me		iene	9. 2	12	66
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	Physic /Medi		CHARLIE	EDWARD	1	OUN	G				AUG	Dey 17	9°9	3:	30PM
	Exami		4a. Facility Name (If not institution, giva	street and number)				4			tion of Death	4c. Count	y of Death		
				ANK RD					PRES		J .	CA	ROLLI	VE	
	Funeral		5. Social Sacurity Number 6. Sa 219 - 30 - 0288	X 7. Age	(In yrs. I	ast birthday)	If Und Months	ar 1 Yaar s Days	If Undar 24 Hours	4 Hrs. 8	B. Date of Birth (Month, Day)	Yearj	9. Birthp	piaca (Stat	a or Foraign
	Director		Usual Residence of Decedent			6 5 Yrs.				J	AN.31	, 193	4 Vi	rgin	i a
	hand hand		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside	City Limits
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	ith with the Marylar 23a or 28a-f show	Director	10e. Street and Number				10f. Z	ip Coda				0g. Citizan of			
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	or dear	Funeral	11, Marital Status	12. Was Decedant E Armed Forces?		S. 13. \	Vas Dec	edent of Hi ecify Cuba	spanic Origir n, Mexican, I	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		ca - Amaric		
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pu	be file tal Hy d oth	Be	17. Father's Name (First, Middla, Last)	D 1	.,						First, Middla, I		ma)		
<u>\Z</u>	Men Men Merke	ို		Robert	You						Perk				
Maryland 21215-0020	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic avant, the Marical Examiner must be notified at		19a latomant's Name/Relationship (7)	ype, Print) g/Spouse							Pouta Number Pres				
	Pages 1 and 2 nent of Health ; int: if item 27 ls ury or other tre		20a. Method of Disposition	37 3 p o u 3 e	20b. Pi	lece of Dispo	sition (N	am a of		, ,		20c. Location			
Baltimore,	ages ant of t: # h		1 ☑ Buriai 2 ☐ Cremation 3 ☐ F		CE	ematary, cran	natory or	othar place	-	0		urloc			and
E			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licens		La				s of Facility	07	23		.,		
ä	permit. Departrimporta		1 0 1	Glowa		F	amp	tom-	Hawk	ins-	Eskow	Fune	ral	Home	, PA
			23a. Part1. Enter the disease, or comp shock, or heert feilure. List only o	lications that caused t	ha daath	Do not ente	er the mo	OX 43 ode of dylng	g, such as ca	ardiac or	t ISDUP respiretory arr	M الا و g est,	2103	Approxin	ate
d	Physician		SHOCK, OF HEER TENDER. LIST OTHY O	ne cause on each line	y.									Interval E Onset ar	d Death
	/Medicai Examiner		Immediate Cause (Finel disease or condition	METH	STI	ATIC	4	OLO	W C.	ANC	ER			6 M	ONTHS
п	LAdiiiiiei	ایا	resulting in death)			as a conseq	-37	j):						-	
	led nsit	Examiner		b											
	ate be executed hysician and the burial-transit	xar	Sequentially list conditions, if any, leading to immediate		ue to (or	es a conseq	uence of):							
8760,	ate be en hysiclan the buria	dicail	cause. Enter Underlying Cause (Disease or injury that initiated events	c	ue to for	as a consequ	uenne of								
9			resulting in death) Lest	D	ue to (oi	as a consequ	Jelice Di	<i>j</i> .							
Box	eeth certific ettending p	Physician/M		d					_						
	the ett	sici	Part II. Other significant conditions con	ntributing to death but	not resu	Ilting In the ur	nderlying	cause give	on in Part I.		23b. Did to	bacco use co	ontribute to	the caus	e of death?
P.0	± ₹ 5										1 □ Y	s 2 No	3☐ Pro	bably 4	U hknown
Records,	ires tha signed d be de	i by									Ode Weste		24h M	ere eutops	v fladings
Ö		Completed									24a. Was e perform	ned?	av	ailable prid	rto
Rec	has has	dm										-/		death?	-10
Vital			25. Was case refarred to medical						00. 81	15	1 🗆 Ye		11.	Yes 2	□ No
>		To Be	examiner?	Hospital:	2 🗆	ER/Outpatien	1 3 🗆 🛭	Othe	AP*		Check only on		har (Snacii	5/1	
of			27. Manger of Death	28a. Date of Injury (Month, Day		28b. Time of	. 001	28c. Injury Work		1	d. Describe ho			,	
io	Attending F or death. Octor: After by the funer	atio	1 Matural 5 ☐ Pending Investigation	(world, Day	, ear)	Injury	M		res 2□No	0					
Division	r Atter de lirecto	Certification:	3 ☐ Suicida 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	y - At ho	me, farm, stre	at, facto	ory, office		28	f. Location (St City or Town		ber or Rura	al Routa N	umber,
	urs eff ral Di														
	Hosp 24 ho Fune Stely f	edicai	29a. Certifier (Check only one) 1 Certifying Physone 1 Medical Exami	sician: To the best of ner: On the basis of e	xamineti	vledge, de <i>a</i> th ion end/or inv	occurre estigation	d at the tim in, in my op	e, dete end p einlon, deeth	place, an occurred	d due to the ca et the time, d	ause(s) end m ete end plece	nenner as s , end due t	tated. o the caus	e(s)
	To the Hospital or Attendity within 24 hours effer death. To the Funeral Director: A completely filled in by the formal of the formal completely filled in th	Mec	29b. Signature end title of certifier	and manner state	ou.		2	9c. License	nu <i>m</i> ber		2	9d. Date sign	ed (Month.	Day, Year)
	F ≯ F Ö		Altan	Ma	Q			D 00	5290	9		08/20			
			30. Name and address of person who co	empieted cause of de	ath (Item	23a) (Type.	Print)						-		
			DAN SOTIRES		A	BALTI	mon	E. 2	25.	GRE	ENES	T. BA	LTIN	ORE	
	Sta	10.0	31. Date filed (Month, Day, Year) AUG 2 3 19	32. Registrar				/							
	Registr	ar	MUU 60 19	77	Array .	0		1000 1	1.1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Haron 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number 4c. County of Deet GENESIS ELDERCARE SEVERNA PARK SEVERNA PARK ANNE ARUNDEL CO. 6. Sex 1 → 2 → F 7. Age (In yrs. lest birthday) 78 Yrs. 5. Sociei Security Number if Under 24 Hrs. 8. Dete of Birth (Month, Day, June 15 9. Birthpiece (State or Foreign Country).
Cambridge, Md. Months Deys Hours Min 213-14-1809 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Co. Md. Pasadena 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8264 Waterford Road 21122 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 XDivorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementery/Secondery (0-12) College (1-4or 5+) Board of Education Custodian 4 0 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Henry L. Aaron Clara Fitzhugh 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 19e. informent's Neme/Relationship (Type, Print) Duke Aaron, Jr. 8250 Baltimore Annapolis Blvd. Pasadena, Md. 21122 (Son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBuriel 2 Cremation 3 Removel from State Glen Haven Memorial Park 9/03/99 Glen Burnie, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 23e. Pert1. Enter the disease, or complications that celestrate deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each unit. Approximete intervel Between Onset end Deeth immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Musc 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably Tolunknown 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Wes en eutopsy performed? ten ner 1 ☐ Yes 2 No referred to medical 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

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traumstic event.

2 should be filled within 72 hours after on and Mental Hyglena.

Is marked other than "natural", or ite.

mit. Pages 1 and 2 pertment of Health e cortant: If Itam 27 ls / Injury or other tra

permit. Page Depertment of Important: If any injury or

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital or Attanding Physician:

Tha law certificata has

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death

Examiner the burial-transit be executed end attending physician Physician/Medical as peu the signed by PV 8

Completed Be P

Certification: To the Hospital or Attandin within 24 hours aftar death.

To the Funeral Director: Af completaly filled in by the fu Medical

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After

death.

State Registrar

Pert ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. injury et Work? 1 Neturei 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) determined 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner es steted.

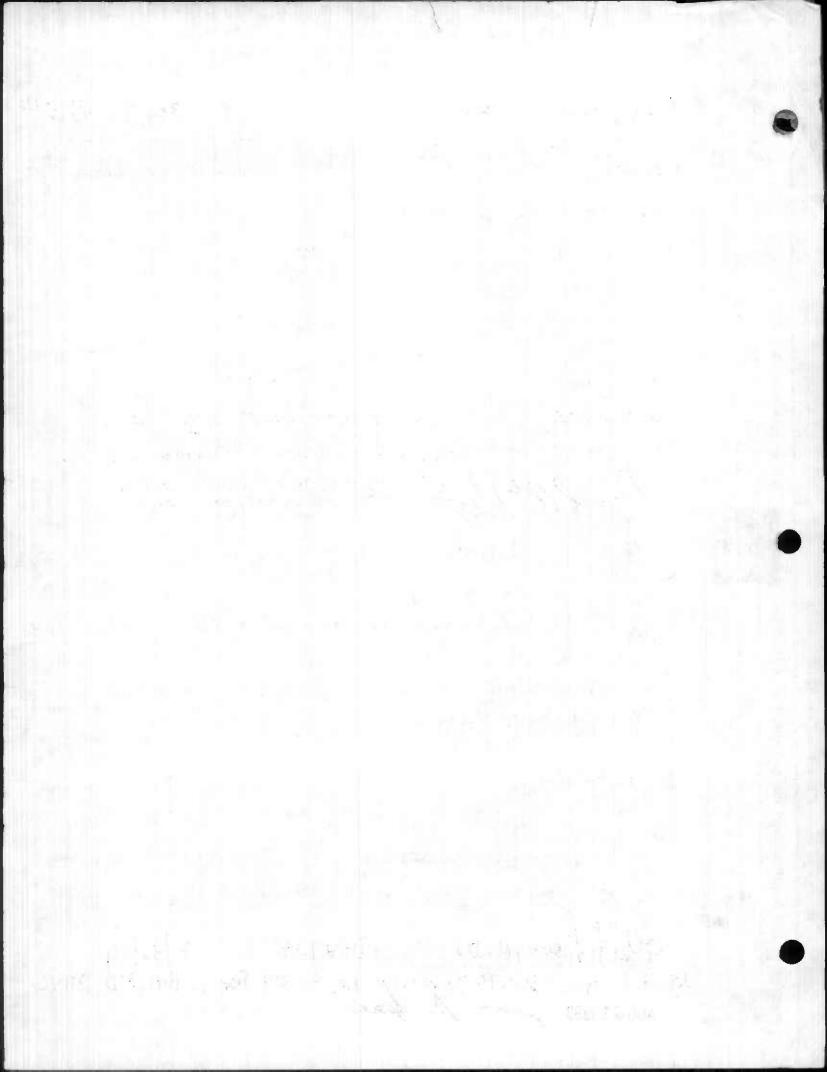
Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only

295. Signature and title of pertition 29c. License number

29d. Dete signed (Month, Dey, Year)

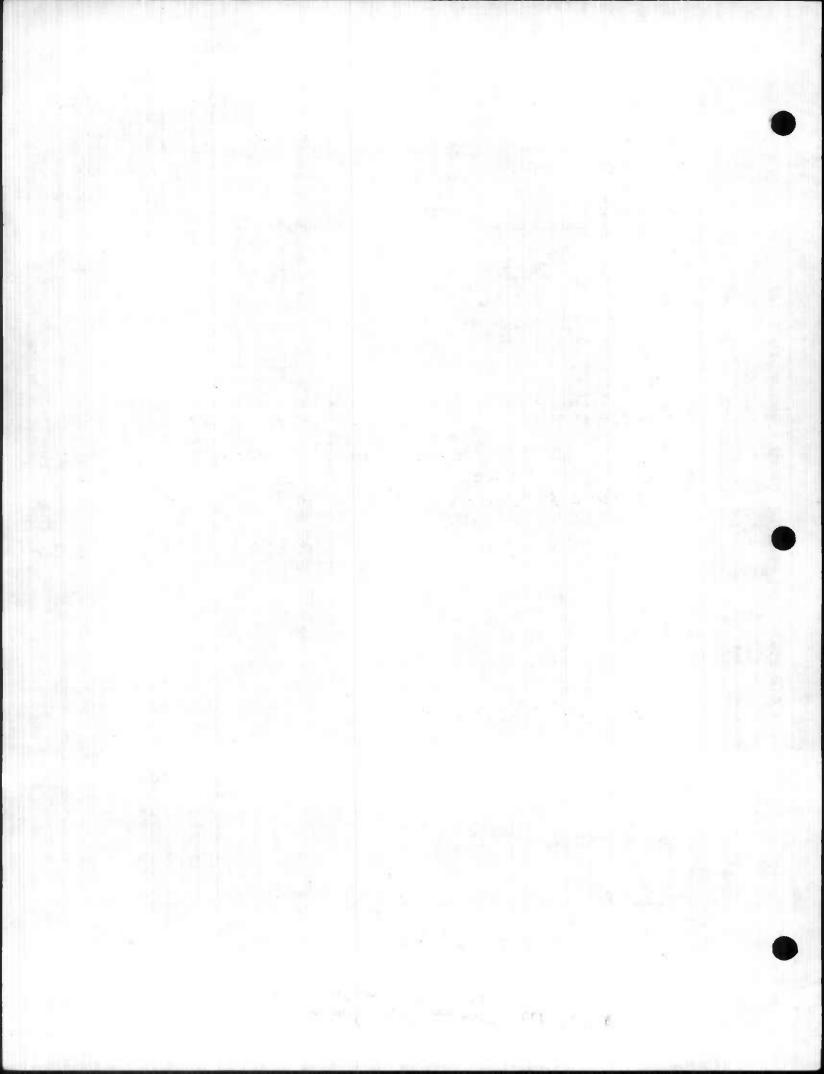
who completed ceuse of deeth (item 23e) (Type, Print)

Jumes Hole Rd, Ste. 304 Severne Purk, MD JOHN F. LOOME 31. Date filed (Month, Dey, Year) 32. Registrar's AUG 3 1 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

	1. Decedent's Nama (Fire	st, Middle, Last)		081	tificate of	Dealli		ate of Death	j. No.		3. Time of Death	
Physician /Medical	Concettina	Rosari	o Albi					08	729/19	99 ^y	Year	4:45AM	
Examiner	4a Facility Nema (If not it 1637 Lochwo						4b. City, Town Baltim		of Death	4c. County			
Funeral Director	5. Social Security Number 216-54-4977		× 2	i (In yrs. la	st birthday) Yrs.	Months Days		Hrs. 8. Da Min. 09	yate of Birth Month Day, Year) 112/1903 Maryland				
yland		County			Town or Loc	ation					1	0d. Inside City Limits	
with the Marylar a or 28e-f show the notified at Director	MD N	/A		Balt	imore							1) Yas 2□No	
with the Ma s or 28e-f s be notified Director	10e. Street and Number					10f. Zip Code			100	g. Citizen of V	What Cour	ntry?	
e 23a Duel	1637 Lochwo	od Cour				21218				nited !			
OZO ours after death v ef, or herne 23e Examiner mat Dy Funeral	11. Marital Status 1 Nevar Merried 3 Widowed 4 1		12. Was Decedant E Armed Forces? 1 Yes 2 W N If Yes, Give Yeer or Detes:			/as Decedent of a Yes, specify Cub. ☐ Yes 2 1 No		7 (Specify Y Juerto Rican,	es or No- , etc.)	Bled	ck, White,		
72 72 72 72 72 72 72 72 72 72 72 72 72 7	15. [(Specify on	Decedent's Edu	ication le completed)	2	16a. Deced	ent's Usuel Occu kind of work done O NOT use retire	pation during most of	working	16	Bb. Kind of B	usiness/Inc	dustry	
Maryland 21215-0020 of 2 should be filed within 72 hours at this and Merical Hydron "natural", or T is marked other than "natural", or T warmeric event, the Medical Exam To Be Completed by I	Elementary/Secondery	(0-12)	College (1-4or 5	+)		<i>o not use retire</i> naker	id)		Own Home				
ent, 1	17. Father's Neme (First,	Middle, Last)					18. Mother's	Neme (First	, Middle, Ma	iden Sumen	ne)		
Vian Wents Wents office To B	Joseph Saia						Provid	denzia	Broca	ito			
and the same	19e. Informent's Neme/F	leletionship (T)	rpe, Print)		19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
e, N 1 and 2 Health em 27 t	Mario E. A	lbi/Sor	1	6700 01 11111 0 1 1 1 1 1 1 1								21013	
Baltimore, emit. Pages 1 sr Montant: if Item 2 my Injury or other ficts.	20a. Method of Disposition 1X Burial 2 Cre 4 Donation 5 0	mation 3 F Other (Specify)		Park		ition (Neme of etory or other ple Cemetery		08/3		oc.Location - Baltimo		Maryland	
Depart Import	21. Signeture of Funerel Christe	service Licens	*Christina Davi	L. Dav	Le	Neme end Addr onard J. R 05 Harford	uck. Inc.	altimon	e, Mary	land 2	1214		
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licate be physicials the burners to burners	Sequentially list condition if any, leeding to immedicause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	ns, ete	o	as e consequ						t			
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Physics of Physics of	Pert il. Other algnificant	OER.		O A	1	derlying cause gi	ven in Pert I.		1 ☐ Yas	/	3 Pro	the cause of death bably 4 Unknow	
aw requires been s 2 should pleted								2	4a. Was an performe		av	era autopsy findings eilabla prior to mpletion of cause death?	
= F # B 0									1 🗆 Yes	2000	1[Yes 2□ No	
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Or VITAL Physician: T this certificat ral director, pa	1 Yas 2 No		dospitel: 1 Inpatier	-	R/Outpatient	3LI DOA				ce 8 Oth		y)	
Attending F ar death. ector: After by the funer tiffication:	27. Menner of Deeth 1 Neturat 5 2 Accident	Pending investigation	28a. Dete of Injur (Month, Dey	Year) 2	8b. Tima of Injury	28c. Inju Wo M 1	ryat vrk?]Yes 2 ☐ No		escribe how	r injury occur	red		
DIVISION (Lat or Attanding P rs after death. at Director: After t ed in by the funer Certification:		Could not be determined	28e. Plece of Injubuilding, etc.	ry - At hom . (Specify)	ie, ferm, stre	et, fectory, office	v. Tr	28f. Lc	ocation (Stre ity or Town,	et and Numb Stete)	per or Rure	al Route Number,	
hound hou	29a. Certifier (Check only one)	entifying Plys	rician: To the best of ner: On the basis of end manner stat	examinetio	edge, deeth n and/or inv	occurred at the ti estigetion, in my	me, date and popinion, death	place, end du occurred at t	ie to the cau he time, date	se(s) and ma e and place,	annar as s and due to	tated. o the cause(s)	
To the He within 24 To the Fu complete	29b. Signature and title o	Lu	een	1	200	29c. Licen	se number	4	290	d. Data signe	30/	Pay, Year)	
	30. Name and authress of	person who co	empleted cause of de	eth (item 2	(Type, F	Print)	217	1-	301	to h	1	21214	
State Registrar	31. Dete filed (Month, Da) / V C F V. Year)	32. Registra	r's Signatu	6	Son	NO V	71.	אוע	10.1	10	w. 1-40.1	



Box 68760 of Vital Records. P.O.

Maryland 21215-0020

Baltimore,

OK

that the death certificate be executed The law requires this After Division or Attending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

> State Registrar DHMH 16 Rev 6/95

Certification:

edical

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier (Check only onel

4 ☐ Homicide

Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

28c. Injury at Work?

WM

28a. Date of Injury (Month, Dey Year)

1 Yes 2 No

MARYLAND 21237

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

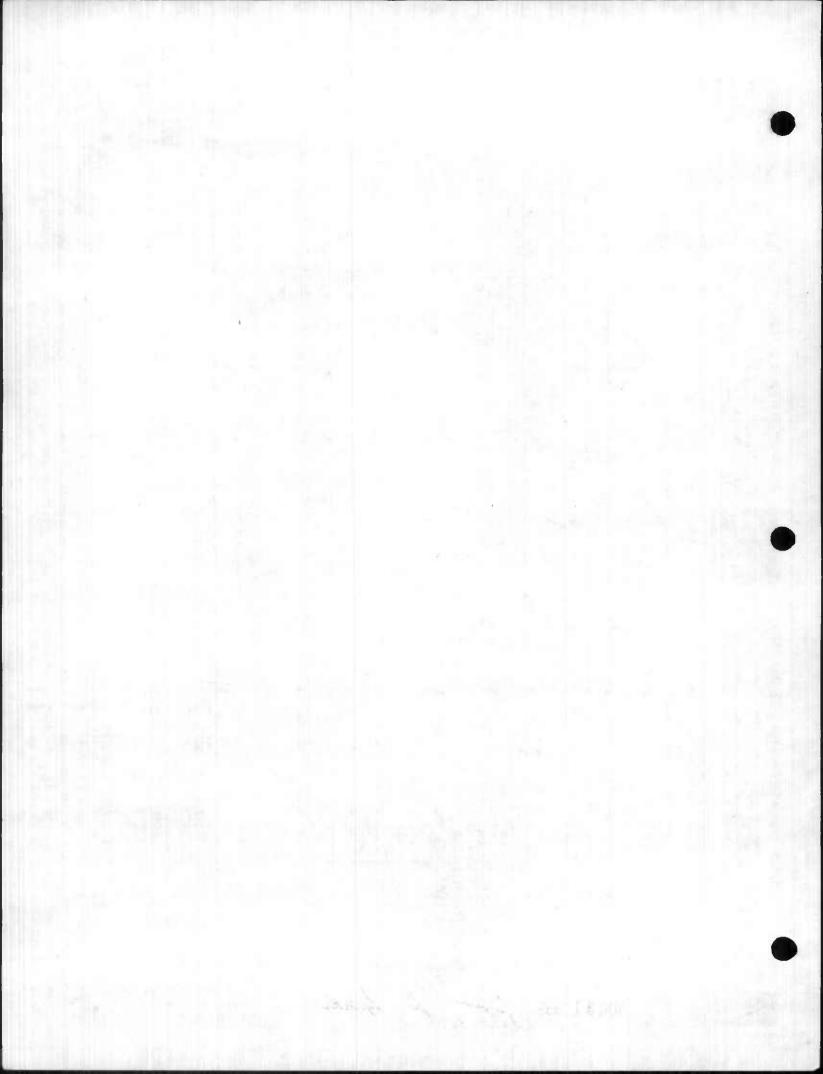
5 Pending investigation

6 ☐ Could not be

DR. JEAN-MAX HOGARTH 9000 FRANKlin SquARE DR. BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Dey Year) 1999 oocks

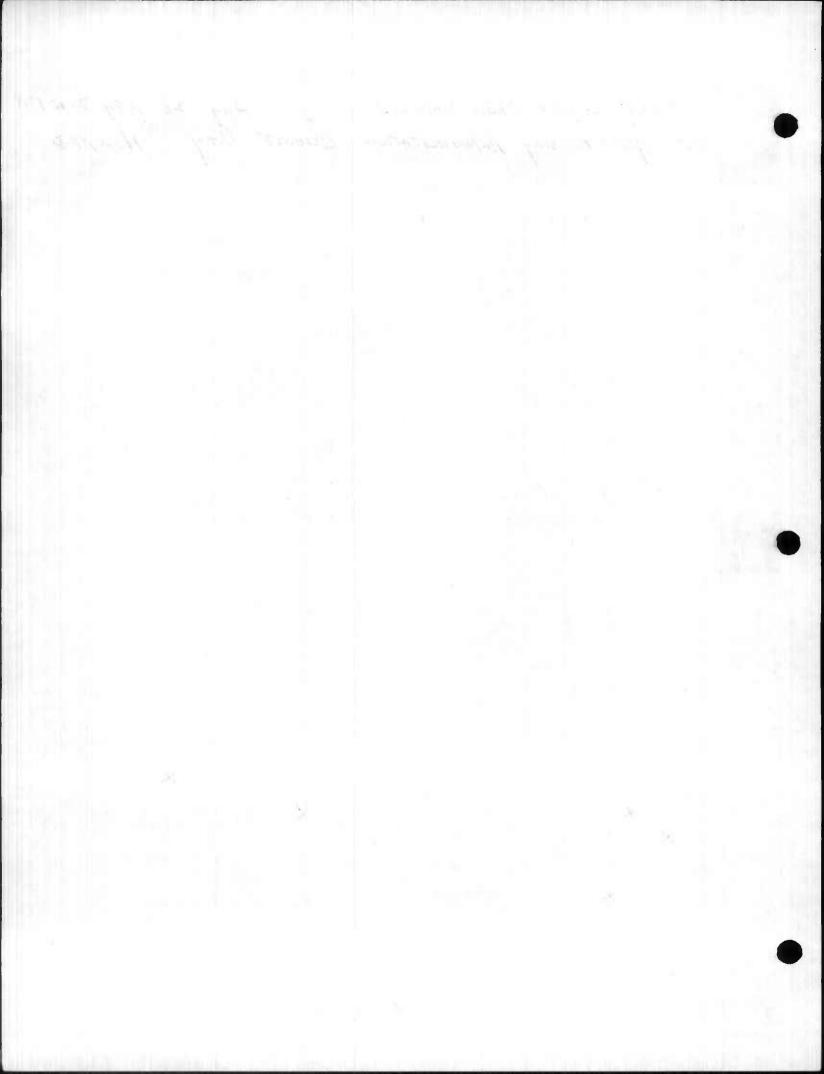
28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 99 27290

					C	ertifica	ate of I	Death		Reg. No.			
	Physici /Medi		1. Decedent's Neme (First, Middle, Lest MARY KEGINT	A MRUECK	MAN	N			2. Dete of Dea	Day 28	1999	3. Time of Death Z:10 Pm	
	Examir	ner	4a. Facility Name (If not institution, give AGNES Nig RS) 5. Social Security Number 6. Sa	street and number)	ILITA	TION	ler 1 Year	L City, Town, or I	Cor	/	Hou	/	
	Funerai Director		215-26-0371 Usual Residence of Decedent	7. Age (myss	Yrs.	Month		Hours Min.	JAN 5,	1926	New New	ace (Stata or Foreign ry) York	
	8a-f show	Director	MD Howard		ity, Town or ${ m Ellic}$	ott					10	d. Inside City Limits	
	ath with the 23a or 2		3000 N. Ridge R	oad		10f. 2	2104	3		10g. Citizan of What Country? USA			
020	hours effer death with the Merylend turet', or Items 23a or 28a-f show at Experience must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ሺWidowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas:	U,S. 13	 13. Was Decedent of Hispanic Origin? (Spill Yas, specify Cuban, Mexican, Puarto 1 ☐ Yes 2X No Specify: 			pecify Yas or No- o Rican, atc.)	14. Rac Blac Specify	a - Amarica ck, Whita, a /: Wh		
21215-0020	within 72 ane. than "nat	Completed	15. Decadent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Git	edent's Usive kind of NOT		etion during most of wor i)	king			stry	
Maryland 2	be filed htal Hygi d other event,	Be	17. Father's Neme (First, Middle, Last) Frank Wieg	and	1 0 9 0	0108		18. Mother's Nam	ne (First, Middle,				
ary	2 should and Meni le marked	To	19a. Informent's Neme/Relationship (7)	rpe, Print)	19b. Ma	iling Addre	ss (Street				Stete, Zip (Code)	
altimore, M	permit. Peges 1 end 2 should Department of Heelth and Mer Important: If item 27 ie marke any injury or other traumatic QDCs.		Russell L. Brueckm 20a. Mathod of Disposition 1 Burial 2 Cremation 3 DF	20b.	comotory, cr	omatory of	Oliver place	0)		dersburg, MD 21784 20c. Location - City or Town, State Baltimore, MD Maryland, Inc. timore, MD 21228			
III	it. Pe intmen intent: njury		4 □ Donation S □ Other (Specify) 21. Signature Funeral Service Cens	Me				Inc. 08/				•	
Ba	Depa Impo		Edward A. Gr	gorchik		299	Fred	erick R	d. Bal	timore	nd, i	Inc. 21228	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart fellipte. List only of Immediate Cause (Finel disease or condition resulting in death)	MALNUTR	ITION			g, such as cardiac	or respiratory ar	rast,	1	Approximate Interval Between Onset and Death	
	p #	ner		ANOREXI	(or es e cons A	equence o	1):				0		
90,	ertificete be executed Jing physician and se es the bunel-transi	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	0. ————	or es a cons	equenca o	f):						
x 68760,	eath certificete be executed ettending physician and for use es the bunel-transit	/Medica	that initiated events resulting in deeth) Lest	Due to (or as a cons			RT DISE	CASE				
Bo	death c	ician	Part II Other significant conditions are								1		
s, P.O.	thet the led by th deteche	by Physician	Part II. Other aignificant conditions con MORFON'S SYNDR		suiting in the	underlying	cause give	en in Part.	23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4				
Vital Records,	aw requir ss been s 2 should	Completed t							24a. Was period	an autopsy med?	aval	re autopsy findings Illable prior to apletion of cause eath?	
a	Page Page		OF Mes and referred to medical						1 🗆 Y		1 🗆	Yes 2 No	
\equiv		o Be	25. Was case referred to medical examiner? 1 □ Yes No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpati	ent 3 🗆 I	Oth	(,	th <i>(Check only o</i> ome 5□ Resid		ar (Snacih)		
ion of	After fune	atlon: T	27. Menner of Deeth Natural Description 5 Pending Investigation	28e. Date of Injury (Month, Day Year)	28b. Time Injury	of	28c. Injury Work		28d. Describe h				
Division	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	ify)				28f. Location (S City or Tow	m, Stete)			
	To the Hospital or I within 24 hours effer To the Funeral Director Completely filled in E	edical	29a. Certifier (Check only one) Certifying Physical Cartifying Physical Examination (Check only one)	elcian: To the best of my knoner: On the basis of examinating and manner steted.	owledge, de ation and/or	eth occurre Investigation	d at the tim on, in my op	ne, date and placa pinion, death occu	, end due to the or rred et the time, o	cause(s) and ma date and placa,	and due to t	ited. the cause(s)	
	To the To the Comp	×	29b. Signature and titia of cartifiar			29c. Licansa number				29d. Date signe	d (Month, D	ay, Year)	
	.11		augu				D290	083		AUGUS'	г 30,	1999	
1	XIV		30. Name and address of person who co Allen J. Chircus,	mpleted cause of death (Ite M.D. 5310 01	m 23e) (Type .d Cou	e, Print) rt Rd	. Bal	timore,	MD21133				
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Regist/ar's Sign	ature	4	las	11					



State Registrar

Medical

29a. Certifia:

29b. Signatura end titla of certifiar

Johns

of person who complated causa of death (Itam 23a) (Type, Print)

Hopkins Oncology Certer Baltimore, Maryland

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. Licansa number

D 52391

29d. Date signed (Month, Day, Year)

DHMH 16 Ray 6/95

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30, 19999:36A.M August Richard E. Busey, Sr. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore tranklin Square Hospital enter osedale If Under 1 Months H Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year)
July 26, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days M 2DF 219-18-0943 75 Director Maryland Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No Director Baltimore 238-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 12 Juliet Lane. Unit #202 21236 U.S.A. Berns 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, than "natural", or had the Medical Examiner Bleck, White, etc. Amed Forces r

1 🖾 Yes 2 🗆 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: White Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Engineer/Professional Musician Telephone Co/Band 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 and Mental James Busey Lillian Werner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 12 Juliet Lane, Unit #202, Baltimore, MD Ruth E. Busey (wife) Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Stete 8 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 9/3/99 Baltimore, Maryland 22. Name and Address of Fecility
Schimunek Funeral Home, Inc
9705 Belair Rd., Baltimore, 21. Signature of Funeral Service Licenses Inc. (Brylo) 21236 23a. Part1. Entar the disease, or complications that cau and the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellural List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel 45 Minutes · Cardiopulmonary disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner monary The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Scheroderma that initieted events resulting in death) Last Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cesa referred to medicel examiner? edicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Inis funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 Pending investigation 1 Neturel within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Hospital 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) To the !

State Registrar

Box 68760,

P.O.

Division of Vital Records.

DHMH 16 Rev 6/95

Dr. Micha

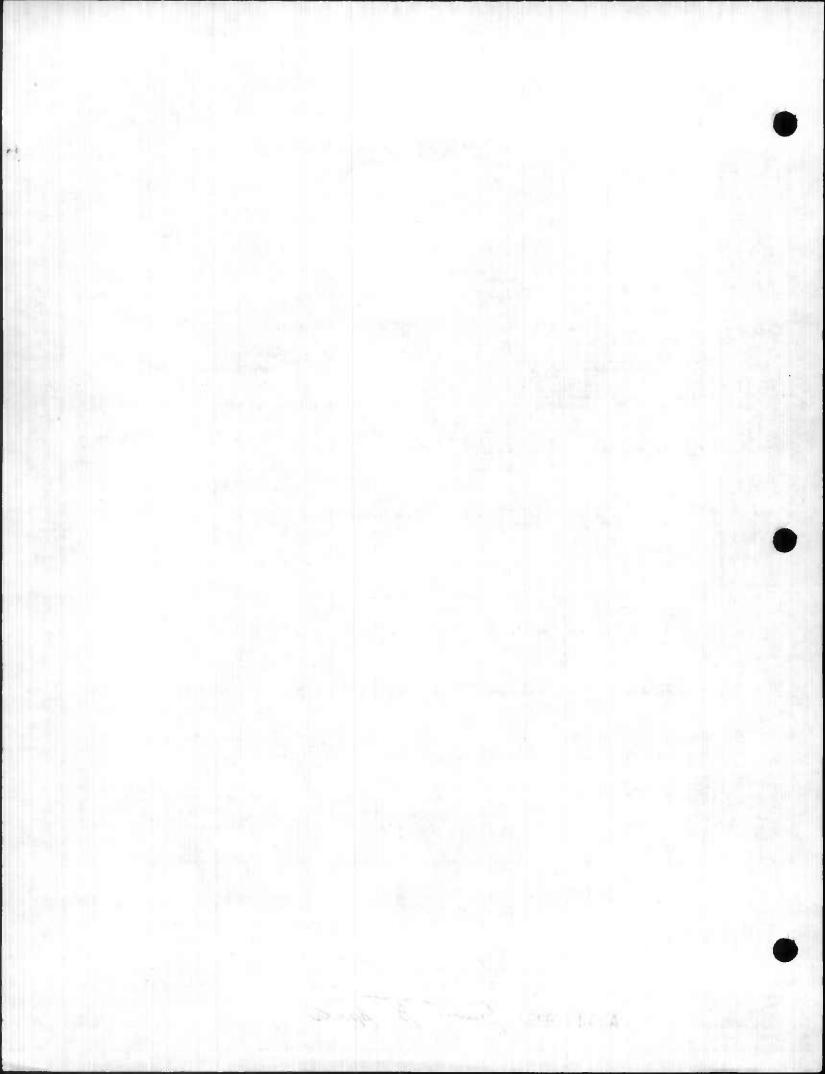
29b. Signature and title of certified

30. Name and address of person who completed ceuse of death (flem 23a) (Type, Print)
Dr. Michael Pipkin 9000 Franklin. Franklin Square Drive Baltimore, MD

ORIGINAL

29c. License number

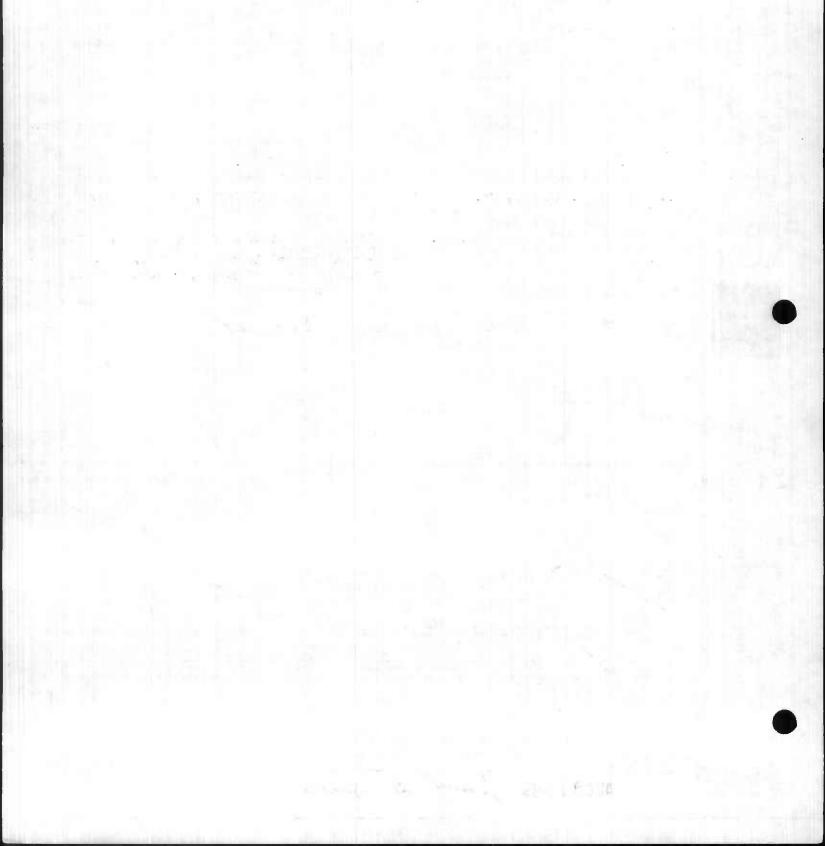
29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 9 9

	Decedent's Nan	ne (First, Middle, La	st)		001	tificate			2. Dat	e of Death	g. No.		3. Time of Death		
Physician									Mo		Day	Year			
/Medical Examiner	Angela 4a Facility Name	Barke 'If not institution, give	45	er)			4t	c. City, Town,		just_ of Death	29 19 4c. County		7:30 AM		
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Funeral	5. Social Security I			Age (In yrs.	last birthday)		Year	If Under 24 h		e of Birth			ace (State or Foreig		
Director	217-38-2	116	□M 2以F	58	Yrs.	Months	Days	Hours N		7 11,		Mary			
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vith the Meryle or 28a-f aho or course Director		Baltimor	е	Dun	dalk										
death with the ring 23e or 28e ring to not the notional Direct	10e. Street and Nu	mber				10f. Zip C	ode		10g. Citizen of Wh			Vhat Count	ry?		
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y Fu	11. Marital Status 1 Never Man 3 Widowed	ried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑No		13. Wes Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:					No- 14. Race - American Indian, Bleck, White, etc. Specify: White				
natural.		15. Decedent's Ed	ducation		16a. Deced	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					6b. Kind of Bu	ainess/Ind	ustry		
lal Hygiena. d other than "natural avent, pre Medical avent, pre Medic		cify only highest gra			(Give I	kind of work OO NOT use	done du retired)	uring most of	working						
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other vent, be Co	17. Father's Name	(First, Middle, Last)			Admi	LIITSCI	_		Jame (First		aiden Sumam		TON CENTE		
a se a												0)			
th and Mental Hyg 7 is marked other treumatic event, To Be C		Bocianov						Angela B. Karcz reet and Number or Rural Route Number, City or Town, State, Zip Code)							
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Health am 27 i	Mr. Gilk	ert T. Ba	arker, Sr		3020	Dun1	eer	Road H	Baltim	ore,	Maryla	nd 21	222		
0	20a. Method of Dis				Place of Disposemetery, crem	sition (Name	of place	3	Date	2	Oc. Location -	City or Tov	wn, State		
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444	4 Donation	5 (AOther (Specif)	Entombm	ent St	Stan	islaus	i Ce	metery	9/4/1	1999	Baltimo	ore,	Maryland		
Department of Important: If eny injury or page.	4 Donation 5 Mother (Specify) Entombment St. Stanislaus Cemetery 9/4/1999 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.														
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aminer	resulting in death)	nesulting in death) Due to (or as e consequence of):													
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her no	27. Manner of Deat	n 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time of Injury	280	: Injury Work	at ?	28d. De	scribe ho	w injury occur	red			
Po f	2 Accident	investigation				М	1 🗆 Y	es 2 No							
al Director: After to led in by the funeral Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of	Injury - At ho	ome, farm, stre	et, fectory,	office			ation (Str.		er or Rura	Route Number,		
급등 등	4 D Homicade	/	building,	etc. (Specifi	7)				UI	y or rown,	State)				
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one)	1 Certifying Phy	niner: On the basis	of examinat	wledge, deeth tion and/or inv	occurred et estigation, in	the lime	e, date end plantinion, death o	ace, end due	to the ca	use(s) and me	nner es st	ated. the cause(s)		
9 de 9			and manner	stated.											
Z con	29b. Signature and	litle of certifier	, ,	./	Λ			number		29	d. Date signe	(Month, L	Day, Year)		
	100	/ 1 /0	thous	3 14 1	J.	7	0	955	7		8/30/	95			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARRY WATERBURY, M.D., JHBAC, 4940 EASTERN AUE., B									1 8/30/41					
	30. Name and add	ess of person who			23a) (Type, f	Print)		1 11	5.	- /	1 21	124	/		
	30. Name and add	ess of person who of		death (Item	23a) (Type, F	Print) DEAS	TEL	U AUE	, BA	J. 1	0. 21	124	/		
State	30. Name and add LARRY (U) 31. Dete filed (Mon	ATERBURY	, h.D. J		23a) (Type, F	Print) DEAS	TEL	U AUE	, BA	J. A	0. 21	124	/		

DHMH 16 Rev 6/95



Physicia /Medica Examine

Funeral Director

, or itsens 23s or 28s-f show aminer must be notified at

Physician /Medical Examiner

been signed by the attending physician and should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

			Cer	tificat	e of	Death			Re	g. No.	9	21231
. Decedent's Nama (First, Middla,	Last)								la of Death	Day	Year	3. Tima of Dea
FRANCIS X. B	URTON							AUC	JUST		1999	2039 F
a Facility Nama (If not institution, g		imber)				4b. City, To				4c. Coun	ty of Deatl	h
902 ASHBURTON ST						BALTI		-		NI	1	
	Sex 1 ☑ M 2 □ F	7. Age (In yrs. le	1000	If Under Months		If Under Hours	24 Hrs. Min.	8. Da	la of Birth onth, Day,	y, Year) Country)		
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MD N	10		TIMOR									1 Yas 2
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0 - 1	9			TOI. Zip		2110				g. Citizen of	110A	unity
902 ASHBURTON	OTREL	sedent Evar in U,S	C 12 V	Vac Doore	3	206 lispanic Ori	inin2 /Cr	anihi V	ne or No	US/1	rican Indian,	
Marital Status Nevar Married 2 Married	Armed F	orces?	3. IS. I	Yas, spec	cify Cub	an, Mexicar	n, Puerto	Rican,	atc.)		ack, White	
3 ☐ Widowed 4 ☐ Divorced	If Yas, G	iva	1 Yes 2 No Specify:							Spec	ily: RI	ACK
15. Decedent'a		zatas.	16a. Decedent's Usual Occupation						1	6b. Kind of		
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21. Signatura of Funaral Sarvine Licensee 22. Name and Address of Facility												
VAUGHN C. GRÉENE FUNERAL SERVICE												
Oaugh (there 5151 BALTO, NATE PIKE, BALTO, MO. 212												Œ
Oayer	CF	Freeze	VA 51.		U C	. GRI	EEN				ERVICE 10. 2	Œ 21229
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) AUG 3 1 1999

WCKE

MO

ess of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

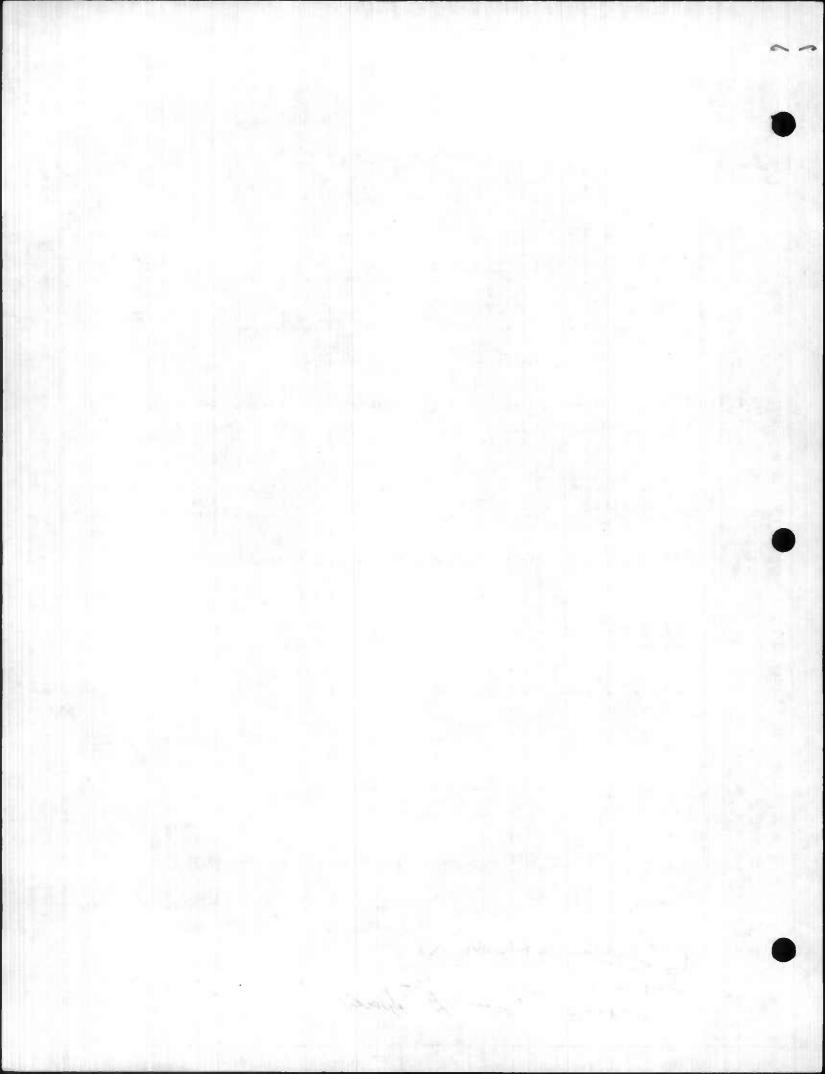
32. Registrar's Signature

Sparks

OCME

AUGUST

29, 1999



If Under 1 Year

10f. Zip Code

Days

Physician
/Medical
Examiner

PHYLLIS 4a Facility Neme (If not institution, give street end number)

August 29 1999 4b. City, Town, or Location of Death

3. Tima of Death 5:25PM

Funeral

5001 Pilgrim Road 5. Social Security Number

Baltimore

4c. County of Death N/A

212-30-9487 Usuel Residence of Decedent

Months 1 □ M 2 🕱 F 66 Yrs.

BELT

Hunder 24 Hrs. 8. Dete of Birth Hours Min. Feb. 9, 1933

9. Birthplace (State or Foreign Maryland

Director

r 28a-f show Inotified at

mast be n

b

Hygiene.

Pages 1 and 2 should be fit ment of Health and Mental H tant: If Item 27 is marked oth lury or other traumatic even

Directo

Funeral

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Completed

Be

with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

10a. Stete 10b. County Maryland

10c. City, Town or Location Baltimore N/A

7. Age (In yrs. last birthday)

10d. Inside City Limits 1X Yes 2 No

10e. Street and Number

5001 Pilgrim Road

21214

10g. Citizen of What Country? United States

11. Marital Status

1 Never Merried 2 Merried 3 Widowed 4 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo Specify:

 Race - American Indian, Black, White, etc. Specify White

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

12 17. Father's Name (First, Middle, Last)

Medical Transcriptionist

5305 Harford Road

Medical 18. Mother's Name (First, Middle, Maiden Sumame)

Willis E. Gross

21. Signeture of Funeral Service Licensee

Ruby E. Coleman 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informent's Neme/Relationship (Type, Print)

5001 Pilgrim Road 20b. Plece of Disposition (Name of cemetery, cremetory or other place)

Baltimore, MD 21214

Baltimore, MD 21214

Mr. George L. Belt / Husband 20e. Method of Disposition

X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 Donation 5 Other (Specify)

Parkwood Cemetery

9/1/99

Dete

20c. Location - City or Town, Stete Baltimore, Maryland 22. Name and Address of Fecility Leonard J. Ruck Funeral Home, Inc.

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be assecuted the burial-transit

Physician/Medical

Be Completed by

Certification: To

Medical

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certificate funeral director,

this

After !

filled in by

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

Timothy Harman

Glioblustoma Multiforme

Approximate intervel Between Onset and Death 4 months

Immediate Cause (Final disease or condition resulting in death)

Due to (or es e consequence of)

23a. Pert1. Enter the discusse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiling. List only one cause on each line.

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yas 2 No

27. Menner of Death 1 Netural 5 Pending Investigation 2 Accident

6 Could not be determined

28a. Dete of injury (Month, Day Year)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 Yes 2 No

26d. Describe how injury occurred

26. Piace of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Yaul & Fully, MD Physican

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year) August 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baul B Fowler, MO 5601 Loch Ruven Blvd, Swite G-4 Baltimore MD 21239 Fowler, MD

31. Data filed (Month, Day, Year)

AUG 3 1 1999

32. Registrer's Signature

State Registrar **DHMH 16 Rev 6/95**

tissis are managed to the weather that the first of the f

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month Day Year MARY A. BRYAN 7:58 A.M. 28, 1999 AUGUST 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN NURSING CENTER BALTIMORE CITY N/A If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Days 1 M 2 F Months Hours 217-34-4003 88 9/01/10 **GEORGIA** Usuai Rasidence of Decedent 10a. Stata 10c. City, Town or Location t 0b. County 10d. Inside City Limits 1 ☐ Yas 2 No BALTIMORE PARKVILLE 10e. Street and Number t Of, Zip Coda 10g. Citizen of What Country? 7909 A WESTMORELAND AVENUE 21234 USA t 4. Raca - Amarican Indian, 12. Was Dacedent Evar in U,S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Armed Forcas? 1 Yas 2000 Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married t ☐ Yas 2 XNo Specify: Specify: 3 Widowed 4 □ Divorced WHITE t6a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) t 6b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12th GRADE HOMEMAKER OWN HOME t8. Mothar's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) HERVEY WELLS EVA SILLS 19a. Informent's Name/Raiationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID L. BRYAN SON 7909 A WESTMORELAND AVE. BALTIMORE, MD 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata XXBurial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 9/2/99 OLIVE CHURCH CEM. RANDALLSTOWN, MD 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility THE JOHNSON FUNERAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON MD shock, or heart failure. List only one cause on each line. Approximata Intarvai Between Onsat and Death Immedieta Causa (Finei disaasa or condition rasulting in death) MOSESIS WEEK Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of): that initieted events rasulting in death) Last Dua to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens.

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important: If it any injury or

Baltimore, Maryland 21215-0020

Physician/Medical Examiner physician and the burial-transit by Completed Be Certification: To this

The law requires that the death certificate be executed

or Attending Physician:

Hospital

r death.

24 hours after deat Funeral Director: 6 filled in

To the F

completely

Division of Vital Records, P.O. Box 68760,

	d					
Part II. Other significant conditions o	ontributing to death but not ra-	sulting in tha under	tying cause	e given in Part I.	23b. Did tobacco use co	ontributs to the cause of death
COPD					1 ☐ Yea 2 ☐ No	3 Probably 4 Unknow
					24a. Was an autopsy performed?	24b. Wera sutopsy findings available prior to complation of cause of death?
25. Was casa referred to medical				26. Placa of De	eath (Check only one)	
axaminar?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	B DOA	Other: 4 Nursing	Homa 5 ☐ Rasidence 6 ☐Oti	har (Specify)
27. Menner of Death t Natural 5 Panding 2 Accident invastigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c.	Injury at Work? 1 □ Yas 2 □ No	28d. Describe how injury occu	rred
3 Suicida 6 Could not be datarmined	28a. Place of Injury - At h	nome, farm, street,	factory, of	lice	28f. Location (Street and Num City or Town, State)	ber or Rural Routa Number,

State

DHMH 16 Rev 6/95

Registrar

Medical

29s. Certifier

29b. Signatu

(Check only one)

och Raven Boulewid, Battimore, Miryland 21239 Kichardson 5401 M.D. 32. Registrar's Signatura

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

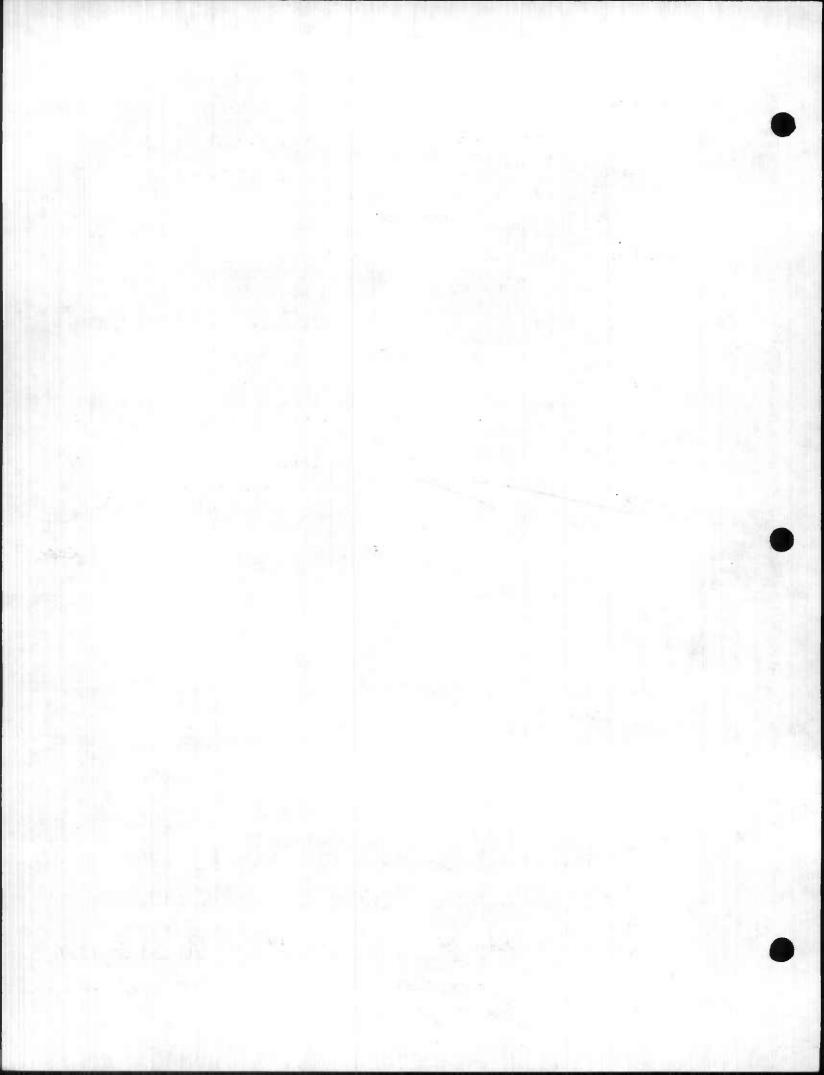
Day, Year) 3 1 1999

ORIGINAL

t 🗹 Certifying Physician: To tha best of my knowledga, death occurred et tha time, date and plece, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and mannar stated.

29d. Data signed (Month, Day, Year)

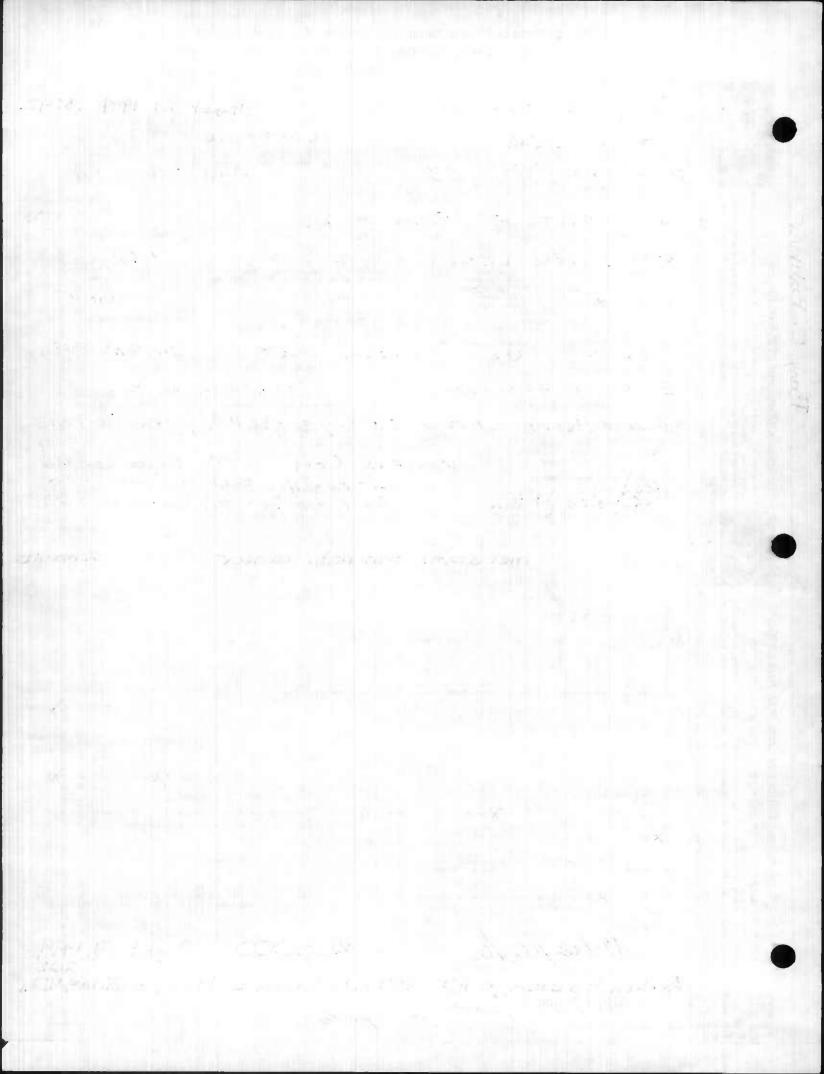


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** PENNY BAHNER 29 13:42 August /Medical 4a Facility Nama (if not institution, giva street and number) 4b, City, Town, or Location of Deeth 4c. County of Death Examiner If Undar 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) BALTIMORE Sinai HOSPIBAL NA 5. Social Sacurity Number 6 Sax 7. Aga (in yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) **Funeral** 219-44-9515 1□ M 28 F Months Yrs. Aug. 11, Director Ma Usual Residence of Decadent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 PKNo MB. PARKUILLE Directo BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8817 1234 ASPER USA LANE Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas, 2 ☐ No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: WITTE þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) DOCTOR'S OFFICE 12 th MEDICAL ASS'T. 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) Be GAWARD PFISTERER 6 MILDRED MISTER 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) REYNOLDS WILL Rd Nock 10 Maghit 276 MELANIE HEFFNER Baltimore, 20b. Place of Disposition (Name of cemetary, cramatory or other place) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Specify) CEM OAKLAWN 21. Signeture Funerel Servica Licensea 22. Nama and Addrass of Facility
HARTLEY MILLER FYNERAL 23a. Part1. Inter the disease, on the lice ions that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 7527 21234 Approximata Interval Between Onsat and Daeth **Physician** /Medical Immediate Cause (Final tatic pancreatic concer Dua to (or as a consequence of): diseasa or condition rasulting in daath) 2 months · metastatic Examiner Examiner attending physician end for use as the burial-transit certificate be executed Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initioted events resulting In deeth) Lest Dua to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown ğ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy complation of cause of death? page 2 1 Yas 2 No 21 No 1 ☐ Yas certificate 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: 1 Devatural 5 Panding 1 TYas 2 No Invastigation 2 Accident 6 Could not be datamined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Piace of Injury - At homa, farm, straat, factory, office building, atc. (Specify) after Direct 4 Homicide 8 24 hours Purheral Descritiving Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifier edical (Check only one) To the 2 29d. Data signed (Month, Day, Year) 29b. Signetura end title of certifiar 29c. Licansa number 30. Name and address of personumo completed cause of death (Item 23a) (Type, Print) 21215 2401 W. Be Bathimare, MD , lvedere Herzka MD 32. Registrar's Signatura

DHMH 16 Rav 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #1 PER MD G774 8-31-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) AGNES JOSEPHINE CUJDIK 2 Deta of Death 3. Tima of Death 1048 PM August 1999 Josephine . 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Randallstown Baltmore Northwest Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) 10M XIF Months Days Hours Min Yrs. 172-26-1715 66 Feb. 11, 1933 Pennsylvania Usual Residenca of Decedan 10a Stafe 10b. County 10c. City. Town or Location 10d. insida City Limits 1 ☐ Yes 2 No Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Janet Court 21136 United States 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ZNo If Yes, Give Year or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12th Grade 4+ Homemaker Own Home 18. Mother's Name (First, Middle, Maldan Sumame) 17. Father's Name (First, Middle, Lest) Agnes Witzcak Joseph Dembik 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 Janet Court; Reisterstown, Maryland 21136 Andrew J. Cujdik - Husband 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore/Washington Crematory 8/27/99 Laurel, Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 Ja. Ente Approximate interval Between Onsaf and Death the disaasa, or complications that causad tha di art failure. List only one cause on each line. th. Do not entar the mode of dying, such as cardiac or respiratory errest, immediate Cause (Final disease or condition resulting in death) . Sepsis days Due to (or as a consequence of): neumonia days Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of) Mesothelroma months Due to (or as a consequenca of) caval Syndrome weeks Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No 26. Placa of Daath (Chack only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of

physicien and the burial-transit requires that the deeth certificate be axecuted P.O. Box 68760 98 USB Division of Vital Records, s certificate has b director, page 2 s or Attending Physician: this funaral after death. Director: Aft

Physician

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Pages 1 and 2 should be filed within 72 hours after death with and of Heelih and Merlel Hyglena.

Art. If New 72 is marked other than natural; or Hema 23a or introde other than natural covers.

permit. Page Department of Important: If any Injury or

Physician

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Examiner

Baltimore, Maryland 21215-0020

Directo

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Physician/Medical þ Completed Be 2 Certification: Medical

25. Was case referred to medical axaminer? 1 Yas 2 No 27. Mannar of Death 28a. Date of injury (Month, Day Yaar) 28c. injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be datarmined 28e. Place of injury - At home, larm, street, factory, office building, atc. (Specify) 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 D Homicida 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one)

29b. Signature and fittle of certifian gen

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29c. Licansa number 35844 29d. Data signed (Month, Day, Year) 25

30. Nama and address of person who completed cause of death (item 23a) (Type, Print)

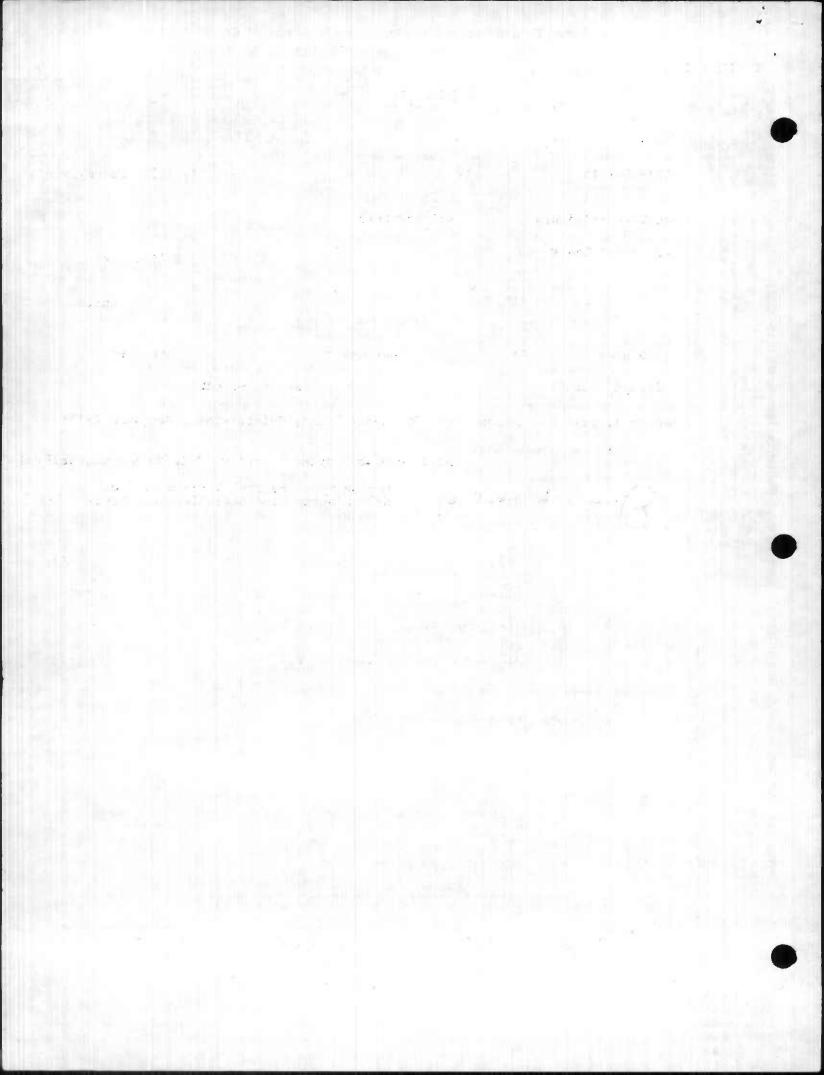
Roggen Randallstown 5401 Old Court Rd

State Registrar 31. Data filed (Month, Day, Year) AUG 3 1 1999 32. Registrar's Signature

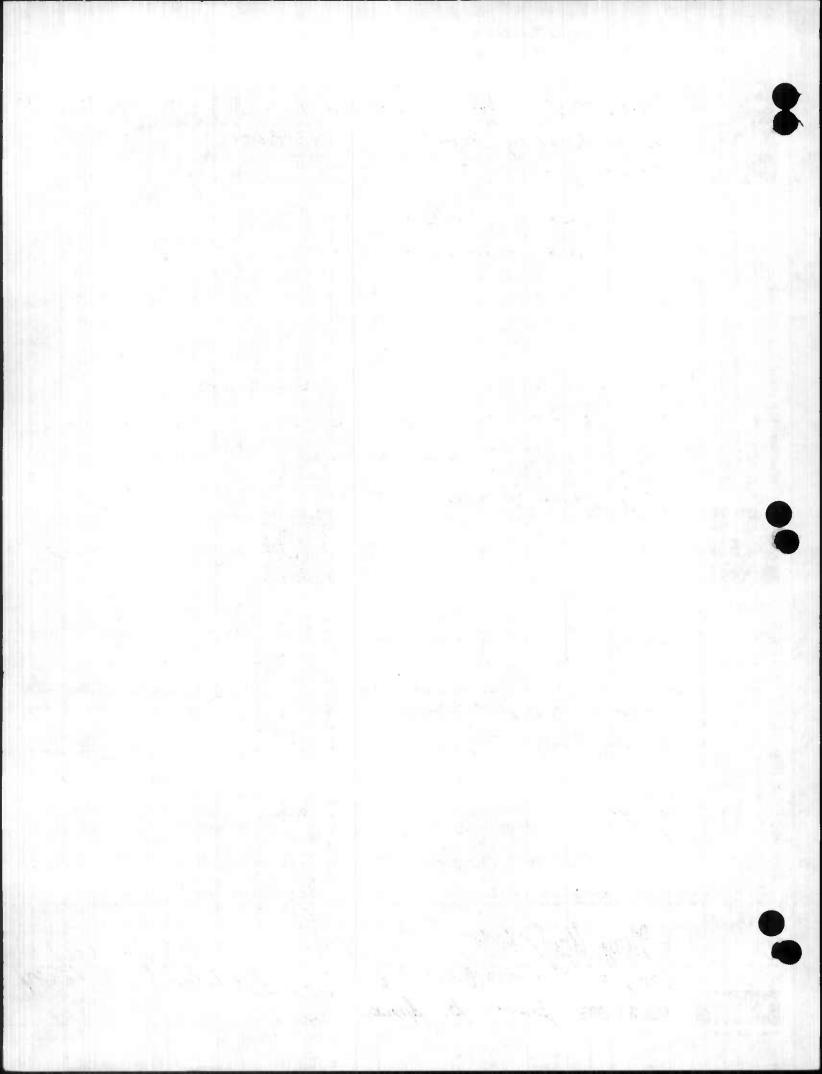
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Physic /Med		1. Decedent's Neme (First, Middle, Let	W.	(ampse	21/	2. Dete of De Month Aug		Year	3. Time of Deeth
Exam	iner	4e. Facility Neme (If not Institution, give 20 V (20 Nav.) 5. Sociel Security Number 6. S	sing How		If Under 1 Year	Baltin			n/a	long /State of Femilia
Funera Directo			ØM 2□F 62	Yrs.	Months Deys	Hours Mir		y, Year) 8 1936		lece (Stete or Foreign try) York
se Maryland 8a-f show	ctor	Md. 10b. County n/a		ity, Town or ltimor					10	0d. Inside City Limits 1 X Yes 2 □ No
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d within 72 hours after death with the Maryland jiene. r than "naturel", or Itema 23a or 28a-f show the Macinal Examiner must be notified at	by Funeral Director	11. Maritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 XDivorced	12. Wes Decedent Ever in Armed Forces? 1 Tyes 2 No If Yes, Give X Yeer or Detes:		212 3. Was Decedent of I If Yes, specify Cub	Hispenic Origin? (en, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ce - America ck, White, o	
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should be filed within and Mental Hygiene. I marked other than umatic event, the Mental Control of the Mental	To Be	17. Fether's Neme (First, Middle, Last) George O. Campbe	ell, Sr.				ome (First, Middle, ia Kraft		ne)	
l end 2 s lealth er m 27 is		19a. Informant's Name/Reletionship (7) George O. Campbe 20a. Method of Disposition 1 Burial 2 Oremetion 3	ell (Son) Removel from State	110 Place of Dis	iling Address (Street 2 Delawar cosition (Neme of emetory or other ple ount Ceme	e Drive,		as, Pen	na. 1 City or To	8336 wn, Stete
permit. Pages Department of Firmportant: If its any injury or of once.		4 Donation 5 Other (Specify 21. Signeture of Funeral Service Licen			22. Name and Addre	ess of Fecility Polyniak		Home P	.A.	
Physician /Medical Examiner physician and ph	ai Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or es e cons	equence of):					Onset end Deeth 4dqs
the death certificate be executed y the attending physician and iched for usa as tha bunat-transit	Physician/Medical	that initiated events resulting in deeth) Lest	Due to (or es a conse	equenca of):					
es that the de igned by the a be detached	by Physic	Pert II. Other significant conditions co	ontributing to death but not re	rhs the	underlying cause giv	ven in Pert I.		obacco use co Yes 2 No	3 Prob	the causs of death?
aw requir 1s been s 2 should	Completed	emphysem	7					en eutopsy med?	con	are autopsy findings hileble prior to inpletion of cause death?
The ata		25. Wes case referred to medical					1 🗆 Y	•	1	Yes 200 No
ing Phys Mer this unaral di	ion: To Be	exeminer?	Hospital: 1 Inpatient 2 Inpatient 28e. Dete of Injury (Month, Dey Year)	ER/Outpetil	of 28c. Inju	Nursing l	Home 5 Resid	lence 6 Oth)
Attender deat	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, s		Yes 2 □ No		ocation (Street and Number or Rural Route Number, ify or Town, State)		
Nexts Hospital or within 24 hours after To the Funeral Dir complataly filled in	edicai	29a. Certifier 1 Certifying Phy cone) 1 Medical Exami	rsician: To the best of my kni iner: On the basis of examina end menner steted.	owledge, dea ation and/or I	th occurred et the time nvestigation, in my o	me, date and ptec pinion, deeth occ	e, end due to the durred at the time, d	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
within To the	×	29b. Signature and title of certified Out Out Out	V long		29c. Licens	e number		Aus 2	d (Month, E)ay, Year) 559
()		30. Name and address of person who co	ompleted cause of death (Ite	5 Hi	CHOVS 1	Ridge 1	Ref Col	lum Si	5 M	70/2/048
St Regist		AUG 3 1 1999	Lever B.	do	als					



1. DECEDENT'S NAME (First, Middle, Last)

Sherman William

Carson

1 - FOR STATE REGISTRAR

3. TIME OF DEATH

6:45 a.m

REG. NO

2. DATE OF DEATH

August 26

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1999 YEAR 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 5. SEX a. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 165-26-5265 1 X M 2 - F October 30,1925 73 YRS. PA Pages 1, 2, 3 should Da. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington IDA STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PA Fulton Warfordsburg 1 - YES 2 X NO permit. 1 FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit Rt.#2 Box 1315 17267 USA Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE -- American Indian, Black, White, atc. 1X Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: Specify: BΥ 3 Widowed 4 Divorced page 5 should be detached for use as the White ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 12 Agriculture Farmer once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at James Carson Achsah Giffin 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 David R. Carson/Nephew 10731 Worleytown RD. Greencastle, PA 17225 Pe 20s. METHOD OF DISPOSITION
1X Burlal 2 Cremation 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director. Amaranth Brethren Cem. 8/30/99 Warfordsburg, PA 4 ☐ Donation 6 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE SELECTION examiner 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, P.A. filled in by the fi 141 W.Main St. Hancock, MD 21750-0368 medicai 23. PART t. Enter the diseases, or complications that aused the des shock, or heert feliure. Liet only one ceuts on each line. aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata interval Between 6 Onset and Death **IMMEDIATE CAUSE (Final** the disease or condition resulting in death) Consistive completely other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): bunial. CERTIFICATION pue Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Mental Hygiene prior to If any, leeding to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF that initieted eventa attending reaulting in death) LAST 10 injury, signed by the a PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24h. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 23 shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO been x. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\frac{\text{S}}{2} \) PHYSICIAN: Dept. certificate has 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item State HOSPITAL:
1 Kinperlant 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 0 the 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 26d, DESCRIBE HOW INJURY OCCURED marked, WITH this 1 Natural TO THE HOSPITAL UN ALLEANDE.
TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death w IMPORTANT. If I tem 28 is mart 5 Pending 1 YES 2 NO ВУ 2 Accident 26e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 3 Suicide 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. (Check only one) 2 🖟 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner ea stated. 29b. SIGNATURE AND 29d. DATE SIGNED (Month, Day, Year)

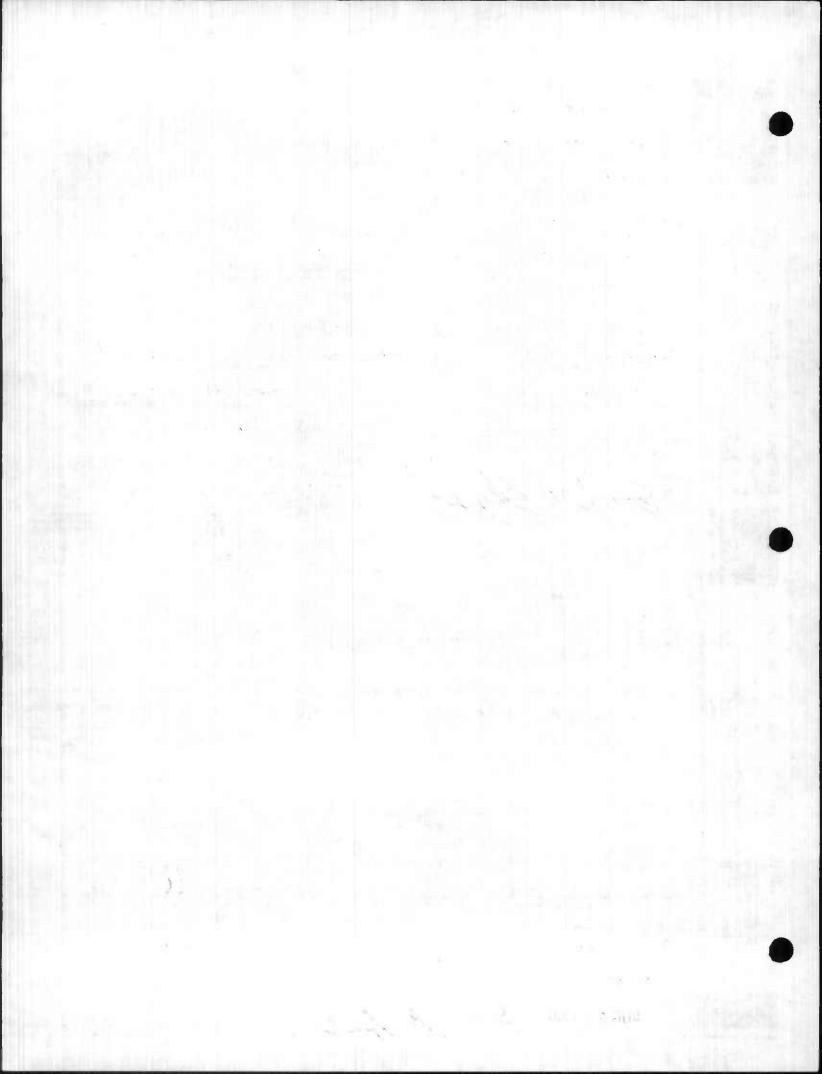
29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER Syed. 2 min BE D52055 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STED 130 -STED HI6H HANCOCK, MI) 57. 2UBAIR 31. DATE FILED (Month, Day, Year) AUG **3** 1 1999

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

			Certifica	ite of	Death	F	Reg. No.	
Physician	Decedent's Name (First, Middle, Last)					2. Dete of Dea Month	Day Ye	
/Medical	Elsie Barbara Der 4a Facility Name (If not Institution, give street			- [tb. City, Town, or L		29,1999 4c. County of E	5:15 AM
Examiner								
Funeral	Eastpoint Nursing F 5. Sociel Security Number 6. Sex	7. Age (In yrs. last		er 1 Year	Dundalk If Under 24 Hrs.	R Date of Birth	Baltime 9.	Birthplace (State or Forei Country)
Director	218-12-8891	2 ⊠ F 85	Yrs. Month	s Days	Hours Min.	(Month, Day	20.1914	Maryland
2	Usual Residence of Decedent					1 0		
ahow ahow	10s. Stete 10b. County	10c. City, T	own or Location					10d. Inside City Limit
vith the Ma to 28a-f a be notified Director	Maryland Baltimor	e	Essex	r. 0. 4	<u> </u>			
Dir			101. 2	ip Code	1		10g. Citizen of What	t Country?
be filed within 72 hours after death with the Maryland of the Upiene. I define the "natural", or items 23e or 28e4 show event, the Medical Examiner must be notified at 8e ompleted by Funeral Director.	922 Lance Avenue	es Decedent Ever in U.S.	13 Was Dan	2122		ecify Yes or No-	U.S.A.	American Indian,
Fundamental Paragraph	_ Ar	med Forces? Yes 2 No	1000000	**	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
by	Maria II	Yes, Give ** eer or Detes:	1 ☐ Yes	26 No	Specity:		Specify:	White
ed within 72 hours att ygiene. ver than "natural", or rt, tre Medical Exam Completed by F	15. Decedent's Education		6a. Decedent's Us		ation during most of work	ring	16b. Kind of Busin	ess/Industry
mple	(Specify only highest grade com Elementery/Secondary (0-12)	ollege (1-4or 5+)	life. DO NOT	use retired	t)	any .		
be filed within tall Hygiene. Id other than event, the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Completed the Manage Be Be Completed the Manage Be	7th. Grade		Salesp	ersor			Retail	
	17. Father's Neme (First, Middle, Last)				18. Mother's Nem	e (First, Middle,	Maiden Sumame)	
should be filed within and Mental Hygiene. I marked other than urnatic event, the M	John Zunt 19a. Informent's Neme/Reletionship (Type, Pi	÷	104 A4-W A-I-I-	(011			ouchnik	T- 0-1-1
W d m m								
Department, Pages I and 2 should became, Pages I and Med III and Med III and Med III and III a	Pauline Herring/ Si	20b. Place	of Disposition (N	ame of		altimore Date	20c. Location - City	21221 or Town, State
Pages ment of I	1 ◯XBurial 2 □ Cremetion 3 □ Remov	al from State	etery, cremetory or			0111100		
artmen ortant: Injury	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Garde			Cemetery ss of Fecility	9/1/1999	Baltim	ore MD
Depart Depart Import any Inj ans	101/m	30 1-			Miller,	Inc.		
		Hyell .	641	5 Be	elair Roa	d Balt:	imore MD	21206 Approximate
Physician	23a. Part : Enter the Susse, or complication shock, or heart facture. List only one cau	salen each line.	20 flot eriter the fire	ood or oya	rg, such es cardiac	or respiretory ar	1001,	Intervel Between Onset and Death
Physician /Medical	Immediate Cause (Finel	SEPSIS						DAVE
Examiner	disease or condition resulting in deeth) a		a consequence o	n.				1 1773
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law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit and a physician/Medical Examiner	Sequentially list conditions,	Due to (or as	a consequence of	f):				
ian a uriat-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
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at the death certific 1 by the attending p etached for use as Physician/Me								
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or signer of bed by						24a. Wes	an autopsy 2	4b. Were autopsy finding
ne law require tale has been si page 2 should t						perfo	med?	evailable prior to completion of cause of death?
the tay						101	es 2 ArNo	1 ☐ Yes 2 ☑ No
certificate irector, pag	25. Wes case referred to medical				26. Place of Deer			10 165 220 110
	axaminer? 1 ☐ Yes 2 ☑ No Hospite	el: 1 Inpatient 2 ER	/Outpatient 3 1	OOA Oth	00 .		ence 6 Other (Specify)
2 2 2	27. Menner of Death 28s		b. Time of	28c. Injur Wor			ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
death. ctor: Aft y the fur	1 ANetural 5 Panding 2 Accident investigation	(mornii, Day 16ai)	Injury M		Yes 2 □ No			
tal or Attending Phy rs after death. al Director: After this led in by the funeral Certification: T	3 Suicide 6 Could not be determined 28	Place of Injury - At home building, etc. (Specify)	, ferm, street, fecto	ory, office		28f. Location (S City or Tow		r Rural Route Number,
O led by								
i o me nospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	(Check only 2 Medical Examiner: 0	To the best of my knowled in the basis of examinetion						
within 24 hours at within 24 hours at To the Funeral D completely filled in	one)	nd manner stated.						
o to o	29b. Signeture and title of certifier	5/4/1/2-	2	9c. Licens	a unumper		29d. Date signed (A	
6	> Marthe n		2	V	13/3/		Lucas.	7 30,1990
Y)	30. Name and address of person who completed Management AB			41 6	3 Adv, w	CARCLO	RALD	D. MD 2122
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** Asa Leete Elliott August 28, 1999 2:45 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Hospice House

5. Social Security Number 6. Sex 7. Age Linthicum If Under 24 Hrs. If Under 1 Yeer 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) **Funeral** Months Hours XXM 2□ F Deys Director 82 017-16-9807 Usuel Residence of Decedent 1/21/1917 New Hampshire 10a. Stete 10b. County 10c. City, Town or Location ne filed within 72 hours after death with the Marylan al Hygiene.

I other than "natural", or flems 23s or 28s-f show vent, the Medical Exert her must be notified at 10d. Ineide City Limits 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Maryland Avenue 21060 S. A. 14. Rece - American Indien. 12. Was Decedent Ever in U.S. Armed Forces?

1 DX es 2 DNo H Yas, Give Yeer or Detes: 194 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Merried 1942 1945 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Electronics Engineer 5+ Westinghouse Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hent: If ham 27 is marked oth jury or other traumatic even Be Ernest Elliott Jeffries W 19a. Informant's Name/Raiationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 310 Maryland Avenue Glen Burnie, Maryland 21060

20b. Place of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, State Martha Evelyn Elliott (Wife) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department o Important: If any injury or 8/30/1999 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center LLC Stevensville, Maryland 21. Signature of Eugeral Service Licansee 22. Name end Address of Fecility Singleton Funeral Home PA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ergoshock, or heart fellure. List only one cause on each line. Glen Burnie, MD 21061 Approximate Interval Between Onset end Death **Physician** tmmedieta Causa (Finel diseese or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): 080 Part it. Other significant conditions contributing to death but not resulting in the underlying cause/given in Pert t. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires thet Records, þ 24b. Ware autopsy findings sveitable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital To the hours after death.

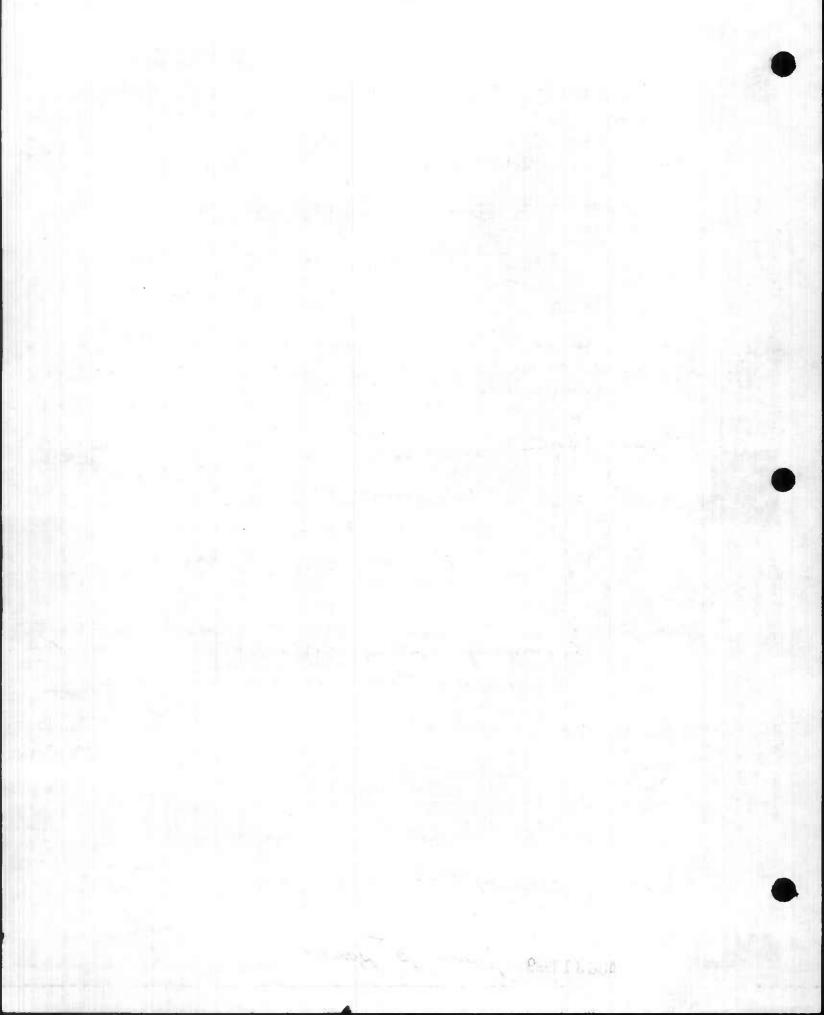
Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case ratured to medice i exeminar? Physician: Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 edical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menney of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 A Naturel 5 Panding investigation 1 Yas 2 No 2 Accident 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of tnjury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifier (Check only 29c. Licanse number 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) me cur 46816 DR. ANIL CHOPPA, M.D. 30. Name and eddress of person who complated cause of death (Item 23a) (Type, Print) FRA 7575 RITCHIE HIGHWAY, GLEN BURNIE, MD. 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rsv 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEMS: #20A-C PER G774 8-31-99 WR. Reg. No 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Year Month FIEDLER August CHRISTINE 23,1999 5:58 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BAHMORE CITY N/A HUnder 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Min. (Month, Day, Year) March 23,1963 HOPKINS THE JOHNS HOSPITAL 7. Age (In vrs. last birthday) If Under 1 Yaar 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Months Deys 1 M 2 KF New York 091.56.5062 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Charlotte 1 Yes 2 No Punta Gorda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33983 U.S.A. 25272 Derringer Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. 11. Marital Status Black, Whita, etc. 1 Never Merried 2 Merried White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Margaret Allback George Frann Belano 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis X. Fiedler/Husband 25272 Derringer Rd. Punta Gorda, Fla.33983 20a. Method of Disposition 20b. Ptece of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Bernovel from Stete ST. PATRICKS CEMETERY 8-28-99 4 ☐ Donation 5 ☐ Other (Specify) SMITHTOWN, NY Sterling-Ashton-Schwab 21. Signeture of Funeral Service License 22. Neme end Address of Facility 736 Edmondson Ave. Catonsville, Md. 21228 omplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. Approximete intervei Between Onset end Deeth MONTHS

Physician /Medical Examiner

physician and s the bunal-transit

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Box 68760.

P.O. I

Division of Vital Records,

Department of Important: If It any Injury or o

Physician

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Examiner

10a. Stata

FLA

Funeral

Director

or 28a-f show a notified at

ð Norms 23a

natural, or

72 hours after

filed within Hygiene.

Pages 1 and 2 should be 1 sent of Health and Mental I nt: If Nem 27 is marked of

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Immediate Cause (Finet diseasa or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical thet initieted events resulting in death) Last

INTERSTITIAL PULMONARY FIBROSIS Due to (or as a consequence of): SCLERADERMA Due to (or es a consequence of) Dua to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.

23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

HYPERTENSION PULMONARY

24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes

YEARS

25. Wes case referred to medical examiner? 1 Yas 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes

27. Menner of Death 28a. Date of Injury (Month, Day Year) 1 Netural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 28b. Time of 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

4 \ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of axaminetion and/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signetura and titla of certified

29c. License number RES-000 29d. Date signed (Month, Day, Year) AUGUST 23, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

JUHNS HOPKINS HOSPITAL TOWER IN BALTIMORE, MO 21287 JAMES M SIZEMORE JR MD 31. Dete fited (Month, Day, Year)

State Registrar

AUG 3 1 1999

32. Registrer's Signature oaks

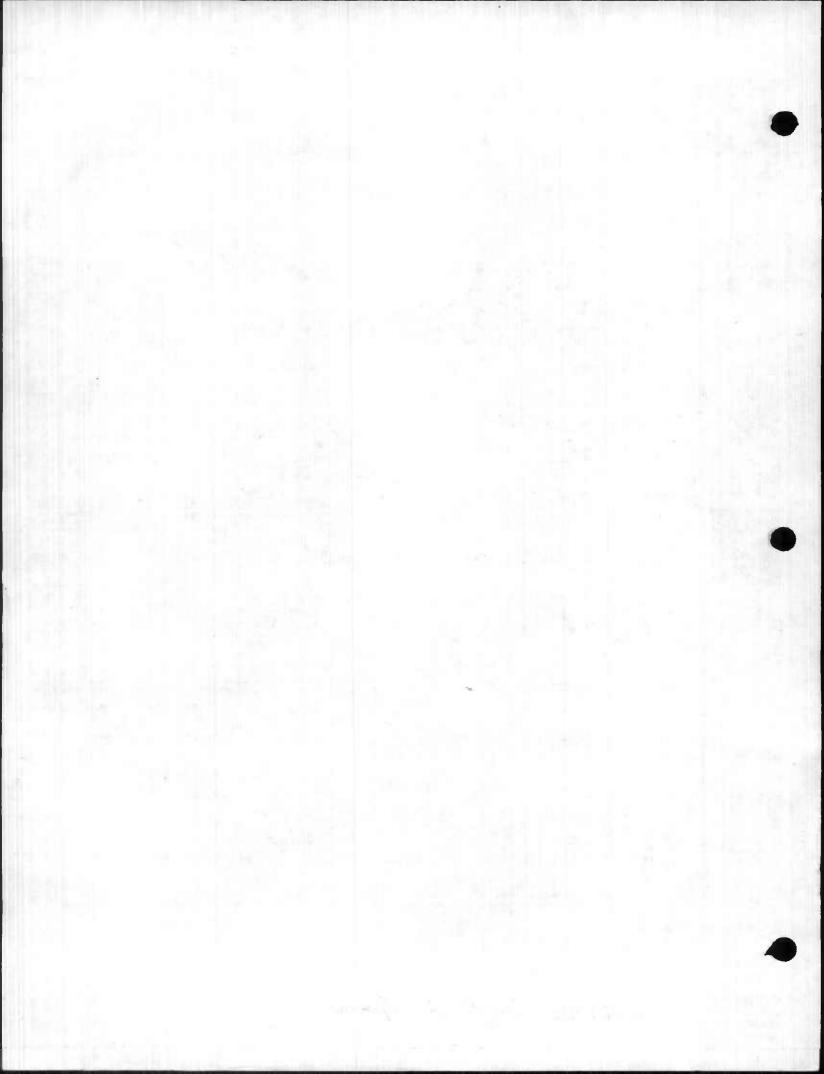
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DHMH 16 Rev 6/95

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			1. Decedent's Neme (First, Middle, La	rst)					2. Defa of De	eth	Vana	3. Time of De	ath	
	Physicia /Medic	_	Rosser		E	TNN	1155		AUGUST	28 1	999	12:59	am	
	Examin	_	4a Facility Name (If not institution, gh	e street and number)			4	lb. City, Town, or	Location of Deat	h 4c. County	of Deeth			
			THE JOHNS HOPKI	NS HOSPITA	L			BALTIMO	MORE N/A					
	Funeral				e (In yrs. I		Months Devs	If Under 24 Hrs Hours Min				aca (Stete or Fo	oreign	
	Director		030-22-8123	1∭M 2□F	68	3 Yrs			NOV 23			husett		
	D .	-	Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or	Location		10d. Inside City Limits					
	aryla ho	2		•	TOO. ON	, 10wii 0i						1 Tes 2		
	V 200	Director	New York Tompk 10e. Street and Number	ins			Ith	aca		10- Citing -(1)	Mark Course			
	E 0 E	ត់		_			10f. Zip Code			10g. Citizen of V		ryr		
	sath	era	504 Lindsay	Lane 12. Was Decedent	Ever in III	E 1		850	Enacifu Vac or No	US.	A a - America	n Indien		
	Per d	5	1 Never Married 2 Merried	Armed Forces?		١.	 Wes Decedent of H. If Yes, specify Cuba 	n, Mexican, Puer	to Rican, etc.)	Bled	k, White, e			
20		by Funeral	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		53	1 ☐ Yes 2 ☒ No	Specify:		Specify	Whi	te		
21215-0020			15. Decedent's E	ducation		16a. De	cedent's Usual Occup	ation		16b. Kind of Bu	usiness/Ind	ustry		
215	7	Completed	(Specify only highest grant Elementary/Secondary (0-12)			(G life	ive kind of work done on the contract of the c	during most of wo ()	rking					
21	r than	EO	Elementary/Secondary (0-12)	College (1-4or 5 5 +)+)		Pastor			CI	hurch	1		
P	offied offier vent, p	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Sumam	10)			
Maryland	should be filed ind Mental Hygi i marked other umatic avent, i	0	Roy Finniss					Ro	se Mar	ie Jef:	fers	on		
an	2 sho and 1 is ma sums		19a. Informent's Name/Relationship			19b. M	ailing Address (Street	and Number or R	ural Route Numb	er, City or Town,	Stete, Zip	Code)		
2	s 1 and 2 f Health tham 27 i		Ruth E. Finni	ss/Wife			Lindsay		Ithaca	, NY 1				
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Demovel from State			sposition (Name of crematory or other place		Dete	20c. Location -				
Ĕ	Pages ment of 8 ant: If he ury or of		4 Donation 5 Other (Special		Met	ro	Crematory	, Inc.	8/28/99	Baltimore, MD MD, Inc.				
Baltimore,	permit. Page Department of Important: If I any injury or page.		21. Signature of Funeral Service Lice				22. Name and Addres	ss of Facility	tu of	MD Tm				
an an	20559		Edward A. G	regarchil	<i>-</i>		299 Fred					1D 212	20	
			23e. Part1. Enter the disease, or com shock, or heart feilure. List only	plicetions that caused	the death	. Do not	enter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between		
S) F	hysician		orioon, or real reliance. Else only	one dead on door m	10.						1	Onset and Dea	ith	
	/Medical		Immediete Ceuse (Final diseese or condition	A	are	Line	6 INUNT				1	2 10.	MS	
l '	Examiner		resulting in death)	a.			sequenca of):				1			
	p 4	dicai Examiner		h No	LTIET	(STET	OREAM	FAILURE				6 HOU	rs	
	and -trans	Тех	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0.	Due to (or	es a con	sequence of):				1			
50,	cian	W	Cause. Enter Underlying Cause (Disease or injury thet initiated events	c Tre	OLAC	0,000	bn. reac	AMERY	507			2 Years	es	
58760,	cate be swocuted physician and the burial-transit	G	thet initiated events resulting in deeth) Last	•	Due to (or	es a cons	sequence of):							
	5 0 6	Me		d										
Box	death certifi e attending ed for use as	lan									1			
0	es that the death cer igned by the attendin be detached for use	Physician/M	Part II. Other significant conditions of	contributing to death b	ut not resu	ilting in th	e underlying cause give	en in Part I.	23b. Did	tobacco use co	ntribute to	the causs of d	leath?	
a	ed by detac								10	Yes 25 No	3 Prob	ably 4 ☐ Un	known	
S	requires free signs hould be	b D							24a Was	an autopsy	24h We	re autopsy find	lings	
Record	v require been si should	Completed								ormed?	eva	ilable prior to opletion of caus		
Sec.	has b	d l									of d	léath?		
= '	cate he								10	Yes 2 No	1	Yas 200 No	1	
Vital	Physician: The contilicate ral director, pag	Be	25. Was case referred to medical axaminer?	Hospital:			tion 20 DOA Oth	or:	eth (Check only					
ō	this all dis	9	1 ☐ Yes 2 No 27. Manner of Death	28a. Dete of Inju		ER/Outpa	tient 3LI DOA	4 Li Nursing I	1	idence 8 Oth)		
5	Affer	Certification:	1 Metural 5 ☐ Pending	(Month, De	y Year)	28b. Tim Injur	y Worl	k? Yes 2 □ No	280. Describe	how injury occur	red			
Sic	Attending ir death. ector: After by the fune	Ca	2 Accident investigatio	8 One Place of Ini	unc - At ho	me form	street, factory, office	165 2 110	28f Location	Street end Numb	er or Rura	Route Number	,	
<u> </u>	Direct		4 ☐ Homicide determined	building, et			street, isciory, onice			wn, State)		. 10010 1101100.		
	ours filled	2	29e. Certifier Certifying Pt	valcien: To the best	of my know	viedne de	eath occurred at the time	ne dete and place	e end due to the	cause(s) and me	nner as str	ated		
	Fundamental	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examinati	ion and/or	investigetion, in my of	pinion, deeth occ	urred at the time,	dete end plece,	and due to	the cause(s)		
1	to the Mosphie or Attending Physicien: within 24 hours after death. To the Fuherral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	1	0		29c. License	e number		29d. Date signe	d (Month, L	Day, Year)		
	- 5 - 0) (e	1	porton		Pes	- 000		Avaist	28.	1999		
	(1)	-	30. Name and address of person who	completed bases of a	eath (Item		on Print)				,			
~ I	/3 \ 1						PO, FIRIL)							
1	X		CHRIS SOMMET-PROT	The Jorens He	SKITS.	Hospi	THE 600 M.	NOLFE ST	TOWAR 11.	Batin	D14 F	TD		
	Stat	P	31. Date filed (Month, Day, Year) AUG 3 1 1999	52. Registre		-	Sparks	Nough St.	Tower (1.	o Brutin	ove, r	עד		

DHMH 16 Rev 6/95



WRC 99-5065-JOHN P. FLANARY

> Physicia /Medica Examine

Funeral Director

•	State of M	narvian(-41	I IAL -		Annan I I I	-i-	-06	1	7001
		iai yiai i				Death		nental Hy	gien Reg. N		3 4	7305
	FLANARY, SR.	r)	14				2. Dete of De Month AUGUST 4b, City, Town, or Location of Deat			ay 19	Year 99	3. Time of Death 9:16 PM.
HARBOR HOS	PITAL	,				B	ALTI	MORE				
. Social Security Number 217–52–2778	1 ☆ M 2□F	Age (In yrs. le 49	est birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	(Month, Di	y, Year		9. Birth	place (State or Foreign ntry) yland
				Ī							10d. Inside City Limits 1 XYes 2 No	
0e. Street and Number 3928 8th 3		10f. Zip Code 10g. Citizen of What Country? 21225 USA					ntry?					
- I ST SWANT	Armed Forces Married 1 ☐ Yes 2 5	}No	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: 11☐ Yes 2☐ No Specify: 12☐ Yes 2☐ No Specify: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- Black, White, etc.) Specify: White					etc.				
			(Give kind of work done during most of working					Kind of B	Business/In	dustry		
Elementary/Secondary (0-	(1-4o	r 5+)		Mill Wright					Lo	cal	1548	
												Code)
		Ce	metery, cremi	atory or ot	her ple		rk 8	Date 3/30/99			- '	
21. Signature of Funeral Ser	Tampton	S.	I	McCul	ly-	Polyn	aik					. 21225
	HARBOR HOS Social Security Number 217-52-2778 Joual Residence of Deceden Oa. State 10b. Con Md. Oe. Street and Number 3928 8th S 1. Marital Status 1 Never Married 2 15. Dece (Specify only his Elementary/Secondary (0-1 10 7. Father's Name (First, Mid Leon J. Flar 19a. Informant's Name/Relat Pauline Flar Oa. Method of Disposition 12 Burial 2 Cremet 14 Donation 5 Othe	HARBOR HOSPITAL Social Security Number 217-52-2778 Janual Residence of Decedent Oa. State 10b. County Md. Oa. Street and Number 3928 8th Street 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 7. Father's Name (First, Middle, Last) Leon J. Flanary 19a. Informant's Name/Relationship (Type, Print) Pauline Flanary (Mother) Oa. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stat 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licence	Social Security Number 217-52-2778 Same HARBOR HOSPITAL Social Security Number 217-52-2778 Sual Residence of Decedent Oa. State 10b. County Md. 10c. City, Town or Loc Baltimore Oa. Street and Number 3928 8th Street 1. Marital Status 1 Never Married Name Na	HARBOR HOSPITAL Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	HARBOR HOSPITAL Social Security Number 217-52-2778 Substitution of Decedent On. State HARBOR HOSPITAL Social Security Number 217-52-2778 1 M 2 F 49 Yrs. 1 M onths Days Hours 10c. City, Town or Location Baltimore 10c. State 10b. County Md. n/a Baltimore 10c. City, Town or Location Baltimore 10c. Street and Number 3928 8th Street 1 Marital Status 1 Merital Status 1 Meri	HARBOR HOSPITAL Social Security Number 217-52-2778 1	HARBOR HOSPITAL Social Security Number 6. Sex 217-52-2778 1 M 2 F 49 Yrs. Moriths Days Hours Min. May 2! Sual Residence of Decedent Oa. State 10b. County Md. n/a Baltimore 10c. City. Town or Location Baltimore 10c. Sty. Town or Location Baltimore 11 Sty. Specify Cuban, Mexican, Puerto Rican, etc.) 11 Sty. Specify Cuban, Mexican, Puerto Rican, etc.) 11 Sty. Specify Specify: 11 Sty. Specify Specify: 11 Sty. Specify Specify: 11 Sty. Specify Specify: 11 Sty. Mailing Address (Street and Number or Rural Route Number or Rural	HARBOR HOSPITAL Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 49 Yrs. Social Security Number 217-52-2778 Sual Residence of Decedent Oa. State 10b. County Md. 10c. City, Town or Location Baltimore 10d. Zip Code 21225 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Specify only highest grade completed) Specify only highest grade completed) Elementary/Secondary (0-12) 10 O Mill Wright Leon J. Flanary 10a. Method of Disposition 1 Specify (Type, Print) 1 Page 1 Sponting Address (Street and Number or Bural Route Number, City 202. Name of Disposition (Name of cemetre), crematory or other place) Cal. Method of Disposition 1 Signature of Funeral Service Licenuse 2 Name of Disposition 2 Name (First, Middle, Lest) 2 Name of Disposition 2 Name of Disposition 2 Name of Facility McCully-Polynaik Funeral House Name (First Name) 2 Name of Disposition 2 Name of Disposition 2 Name of Facility McCully-Polynaik Funeral House 2 Name and Address of Facility McCully-Polynaik Funeral House 1 Signature of Funeral Service Licenuse	HARBOR HOSPITAL Social Security Number 217-52-2778 1 M 2 F 49 Yrs. 49 Yrs. Months Days Hours Min. Month, Day, Year) Months Days Hours Min. May 25 1950 Security Number 217-52-2778 Security Number 218 M 2 F 49 Yrs. Social Security Number 217-52-2778 Security Number 218 M 2 F 49 Yrs. Security Number May 25 1950 Security Number 3928 8th Street 106. County Md. N/a 106. City, Town or Location Baltimore 107. Zip Code 21225 US 108. Zip Code 21225 US 109. Citizen of 21225 US 11 Never Married 2 Married 11 Never Married 2 Married 11 Never Married 2 Married 11 Never Married 4 Married 11 Never Married 4 Married 11 Never Married 4 Married 12 Was Decedent Ever in U.S. 13 Wes Decedent of Hispanic Origin? (Specify Yes or No-Bis Married Free Specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 13 Wes Decedent of Hispanic Origin? (Specify Yes or No-Bis Married Marrie	HARBOR HOSPITAL Social Security Number 6. Sex 17. Age (In yrs. last birthday) 49 Yrs. Morths Days Hours Min. Min. Min. May 25 1950 Mar 217–52–2778 11 M 2 F 49 Yrs. Morths Days Hours Min. Min. May 25 1950 Mar		

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 23s-4 ahow any Injury or other thaumatic avant, in a finding items man be notified at

Baitimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Immediate Cause (Finel disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
Part II. Other significant condition	s contributing to death but not re-	sulting in the underlying cau	use given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death? 3 Probably 4 Unknown
				24a. Wes an autopsy performed? INSPECTION 1 Yes 2 No	24b. Wera autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of De	eth (Check only one)	
examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpetient 2X	SER/Outpatient 3 DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
27. Manner of Death 1 XNetural 5 Pending 2 Accident investiga	156	28b. Time of Injury M	c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could no determin		nome, farm, street, fectory,	office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
29s. Certifier 1 Certifying (Check only and Medical Ex	Physician: To the best of my lost taminer: On the basis of examina and manner stated.	owledge, death occurred at ation and/or investigation, in	the tima, date and place n my opinion, deeth occ	e, and dua to the cause(s) and me urred at the time, date end place,	enner as stated. and due to the cause(s)
Sith Signature and title of continue	1	200	License number	20d Date sinne	d (Month Day Vans)

To the Hospital or Attanding Physician: The law requires that the death certificate be assecuted Division of Vital Records, P.O. Box 68760. within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director,

J. Laron Locke M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

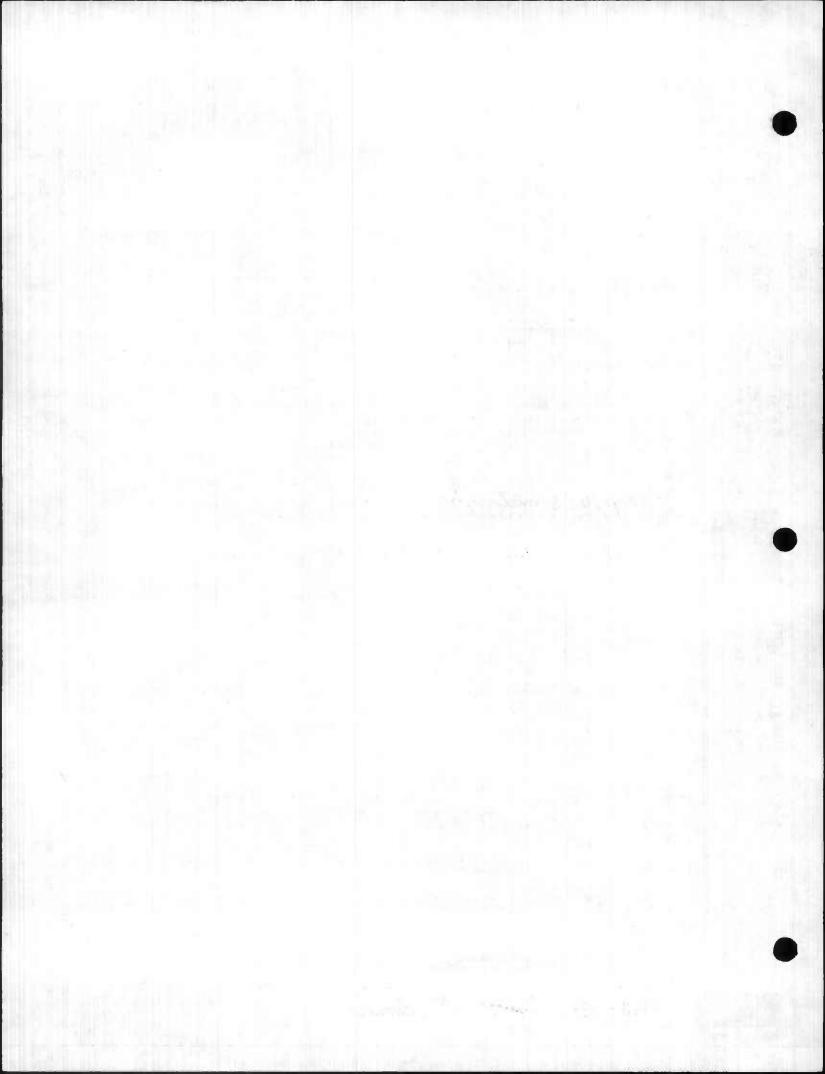
32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

AUGUST 27, 1999

O.C.M.E.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 9 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey FLETCHER 25 DOUGLAS 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death 7. Age (In yrs. last birthdey) BALTIMOLE ff Under 24 Hrs. 8. Date 1115 n/a 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) Months Days Hours 577-64-1129 1⊠M 2□ F 52 1946 28 Washington D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits Anne Arundel Co. Severn 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8143 Quarter Field Farms Road 21144 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Stetus Black, Whita, etc. Armed Forces? 1 M Yes 2 No If Yes, Give Vietnam Yeer or Detes: 1 Never Merried 20 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Dept. of Defense 4 Project Manager 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Bernard Fletcher Pansey Morris 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Linda D. Fletcher (Wife) 8143 Quarter Field Farms Road, Severn, Md. 21144 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 DBurial 2 □ Cremetion 3 □ Removel from Stete Crownsville V. A. Cemt. 8/30/99 4 ☐ Donetion 5 ☐ Other (Specify) Crownsville, Md. 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road. Pasadena, Md. Lora 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel VENTRICULAR FIBRILLATION HOUR diseese or condition resulting in death) Due to (or as e consequence of) MYOCARDIA INFARCTION Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobecco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 20 No 1 Yes 2 No

26. Place of Deeth (Check only one)

PES-000

BALTIMORE

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

CURYLAM

29d. Date signed (Month, Day, Year)

21287

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

8

Certification: To

edicai

25. Wes case referred to medical exeminer?

5 Pending

investigetion

6 ☐ Could not be determined

1 ☐ Yes 2 No

27. Menner of Death

1 Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only 29b. Signature

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

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the Maryland

72 hours after

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Pages 1 and 2 should

Health and Mental marked

В

mportant: If Item 27 is

altimore. Maryland 21215-0020

be executed the signed t The law requires page 2 s

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician: After n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fun Hospital

To the Hosp within 24 ho To the Fune completely fi

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN CHENG

NORTH WOLFE 32. Registrer's Signetura

Hospitel:

1 Inpatient

28e. Dete of fnjury (Month, Day Year)

STREET

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

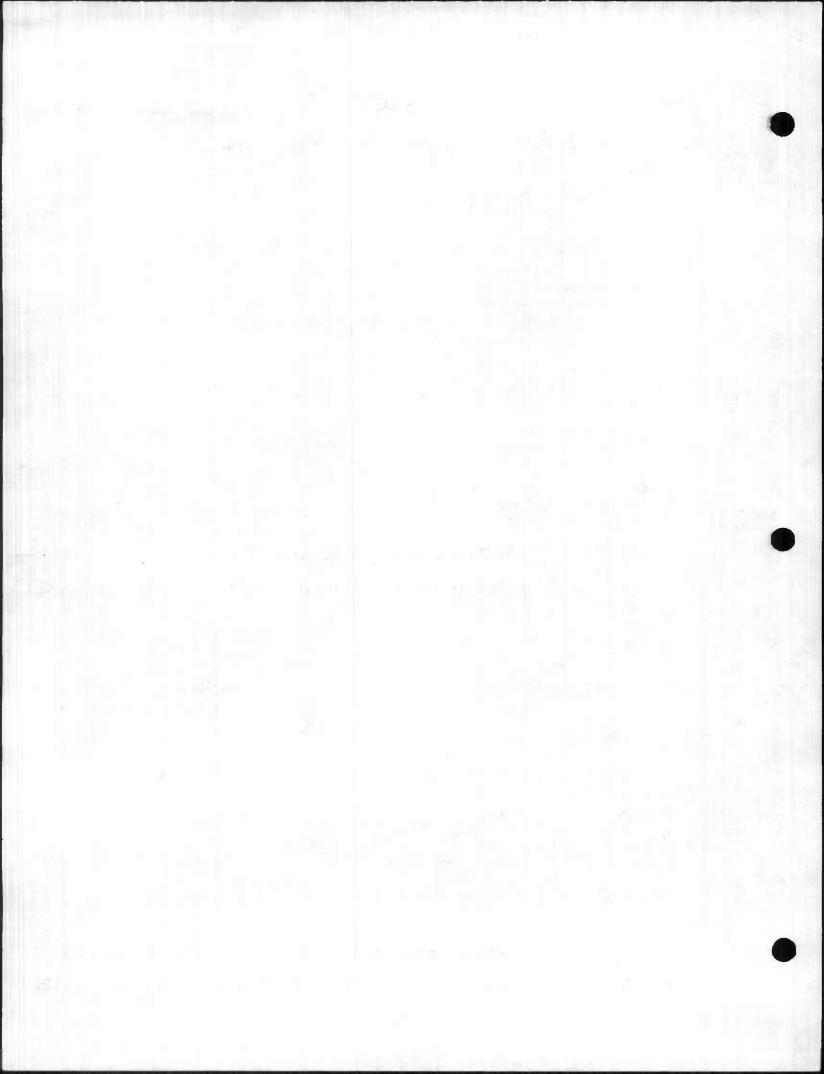
29c. License number

1 Yes 2 No

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

MEDICINE HOUSESTARE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year August 25,1999 Wade Funk 11:45 p.m. 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 8639 Rockoak Road Baltimore Baltimore If Undar 1 Yaar If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Days t € M 2 F Yrs 74 218-12-7567 27, 1924 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8639 Rockoak Road 21234 U.S.A. 11. Maritai Status 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1√∑Yes 2 □ No If Yes, Give Year or Datas: WWII 1 ☐ Never Marriad 2 ☐ Married 1 Yes 2√2 No Specify: Specify: 3 Widowad 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Automobile Body Repairman Automobile 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Sumeme) Henry C. Funk Ruth L. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. Dennis Funk/Son 1728 White Oak Ave. Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/28/99 Woodlawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lide 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or omplications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. Limit help one cause on each line. Approximate Interval Between Immediate Cause (Final diseasa or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2N No 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes

Examiner The law requires that the death certificate be asscuted P.O. Box 68760, Records, Division of Vital

Examiner sician and burial-transit physician s the burial Physician/Medical signed by þ Completed page 2 should has certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: Atter this certifica tiely filled in by the funeral director, p. Be Certification: To To the Hospital o within 24 hours at To the Funeral D completely filled i edical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show ad cal Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after an ant of Health and Mental Hygiene.

All filem 27 is marked other than "natural", or fleiury or other traumate event, the Mental Enature into or other traumate event, the Mental Enature.

Department of Health e Important: If Item 27 is any Injury or other trai

Physician /Medical

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

with the Maryland

State Registrar

Civatural

2 Accident

4 Homicide

29b. Signature and title of

3 ☐ Suicide

29a. Certifier

Huslig, M.D.

5 Pending

investigation

6 Could not be determined

certifie

28a. Date of Injury (Month, Day Year)

Osler

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The distribution of the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

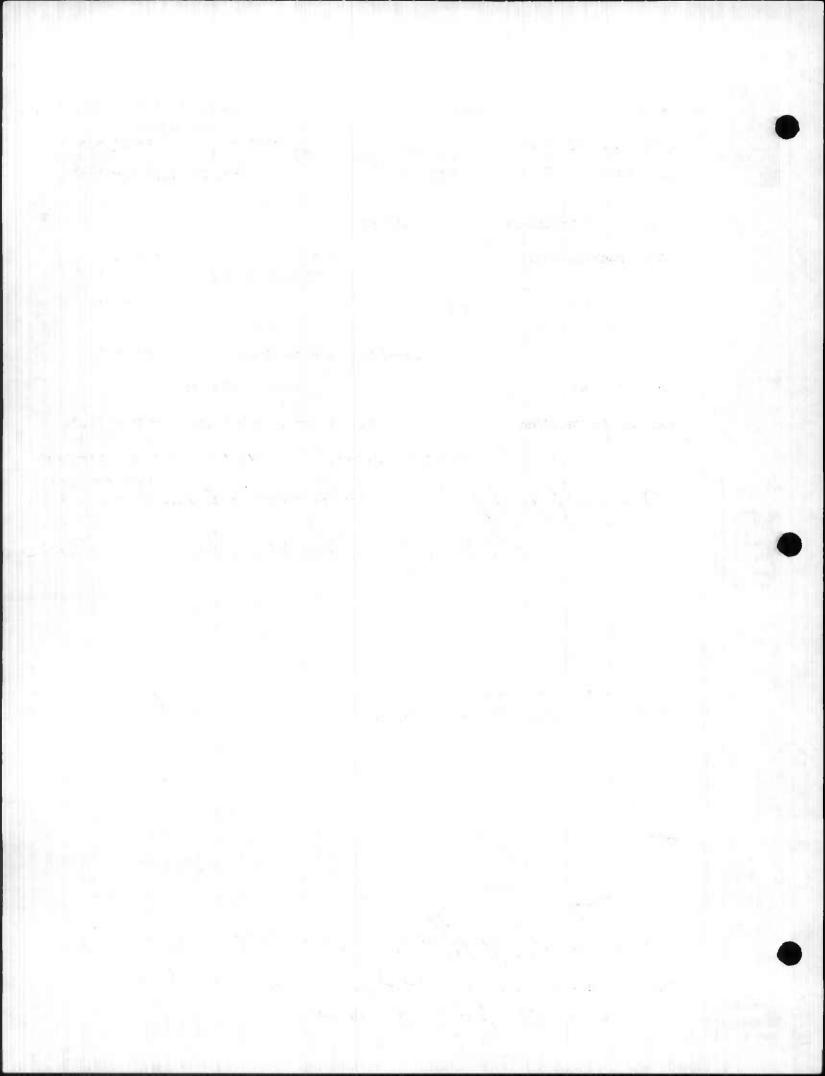
30. Name and address of person who completed cause of death (Item 23a) (Type, P 7505 Drive #302 Towson, Maryland 21204

28c. Injury at Work?

29c. License number

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 3 1 1999





8/27/99 19:20 PM. 6000 G 2

			waryiaria		tificate of		Mental Hyg	eg. No.	2/308
Phys	ician	Decedent's Name (First, Middle, Last) CARDETTE CARDETTE					2. Date of Deal		3. Time of Death
/Me	dical	ROBERT GARRETT 4a. Facility Neme (If not institution, give street and num	(har)		1	4b. City. Town. o	AUGUST or Location of Death	27 199 4c. County of	
Exa	niner	GILCHREST HOSPICE	,			TOWSON		BALTIM	
Funer Direct		5. Social Security Number 6. Sex 1 □ X 2 □ F	7. Age (<i>In yrs. ias</i> i	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		Yaar)	Birthplace (State or Foraign Country) ARYLAND
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Loc	ation				10d. Inside City Limits
death with the Maryland ims 23a or 28a-f show	ctor	MD BALTIMORE	ROSE	EDALE					1 ☐ Yes 2 No
with th	Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
eath w	Funeral	103 ASPENWOOD WAY APT F	dent Ever in U.S.	12 14	2123		(Specify Yes or No-		ISA American Indien,
	Fun	1 Never Married 2 Married 1 Yes, Giv	ces?	11	Yes, specify Cub	ean, Mexican, Pue	erto Rican, etc.)		White, etc.
72 hours aft "natural", or	d by	3 ☐ Widowed 4 ☐ Divorcad If Yes, Given Year or Da	tes:	1	☐ Yes 2 XNo	Specify:		Specify:	WHITE
filed within 72 hours after Hygiena. ther than "natural", or Ite	Completed	15. Decadent's Education (Specify only highast grada completed)	1	(Give k	ent's Usual Occu ind of work dona O NOT usa retire	during most of w	rorking	16b. Kind of Busi	ness/Industry
e filed withir al Hygiena. other than	отр	Elementary/Secondary (0-12) College (1-			MILKMAN	u)		DATR	v
be filed tal Hygid d other	BeC	17. Fether's Name (First, Middla, Last)			TILLEGE ET	18. Mother's N	ame (First, Middle, I		
Mer Mer arks	2		RRETT			ANN			UNK
d d 2		19a. Informant's Neme/Relationship (Type, Print) EMMA R. KELLER / WIF					Rural Routa Number		
f Health tam 27 I		EMMA R. KELLER / WIF	20b. Plac	103 e of Dispos	ition (Nema of	OOD WAY	BALTIMOR	E, MD 20c. Location - Ci	21237 ty or Town, State
Pages nant of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Spacify)	tate MET		atory or othar pla	ica)	8/30/99	BAT TTMOR	E MD
permit. Pages 1 e Departmant of Hes Important: If Itam any Injury or othe	- Suce	21. Signature of Functual Suprem Licenness		22.	Name and Addre				Ε, ΤΕ
205	ă	56				SACO AVE	UNERAL HO	ME RE, MD 2	1237
		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. I ch line.					est,	Approximate Interval Between Onset and Death
Physicia /Medica		Immediate Cause (Finel	una	(ance				
Examine	er	disease or condition resulting in deeth)	Due to (or es			*			18 mm
be iii	aminer	h			,				
mecut n end ai-tran	Ехап	Sequentially list conditions, if any, leading to immediate	Dua to (or as	s e consequ	enca of):				
ficata be exect physician en the burial-tr		cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	0.00000000	0000 0():				
ng phy as th	Medi	resulting in death) Last	Due (0 (0) as	a consequ	erice or).				
eath certific attending p	lan	d							
t tha de by the a	Physician/Medical	Pert II. Other significant conditions contributing to dea	ath but not resultin	ng in the une	derlying cause gi	ven in Pert I.	23b. Dld to	bacco use contr	ibute to the cause of death?
as that the	by Pt		1000	Ves 2 No 3 Probably 4 Unknown					
The law requiras that tha death certificata be executed to has been signed by the attending physician end paga 2 should be detached for use as the burial-transit							24a. Was a		24b. Were autopsy findings available prior to
has be	Completed								completion of cause of death?
							1 □ Ye	a 2 No	1 ☐ Yes 2 ☐ No
ysician is certifi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No Hospital:	patient 2□ER	/Outpatient	3□ DOA Oti	nor:	eeth (Check only on Home 5 - Reside		Consider Has a single
or Attending Physician: The law requires that the death certificate be examined death. Intercheath. Intercheath. In by the funeral director, page 2 should be detached for use as the burial		27. Manner of Deeth 28a. Date of		b. Time of Injury	28c. Inju Wo		T	nca 6 Other w Injury occurred	
r Attending Phy ter death. rector: After this	catic	2 Accident investigation			M 1	Yes 2 □ No			
or Attenafter deat Director: d in by the	Certification:	determined 289. Place of	of Injury - At home g, etc. (Spacify)	, farm, stre	et, factory, offica		28f. Location (St. City or Town		or Rural Route Number,
0 = 0 =		29a. Certifier 1K Certifying Physician: To the b	est of my knowled	dge, death	occurred et the ti	me, date end plac	ce, end due to the ca	use(s) end menn	er aa stated.
spital o nours aft neral Di	100		to of our minesting	and/or laws	etigation in my	minion death on	curred at the time de	te and place, en	d due to the course(e)
he Hospital o in 24 hours aff he Funeral Di pletaly filled in	edicai	(Check only one) 2 Medical Examiner: On the besend mann	er stated.	and/or inve	stigetion, in my (phillion, death occ	our od ut pro timo, de	no and piood, on	due to the cause(s)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completaly filled in by the funeral director,	Medica	(Check only 2 Medical Examiner: On the bes	er stated.		29c. Licens	se number		9d. Date signed (Month, Day, Year)

DHMH 16 Ray 6/95

State Registrar

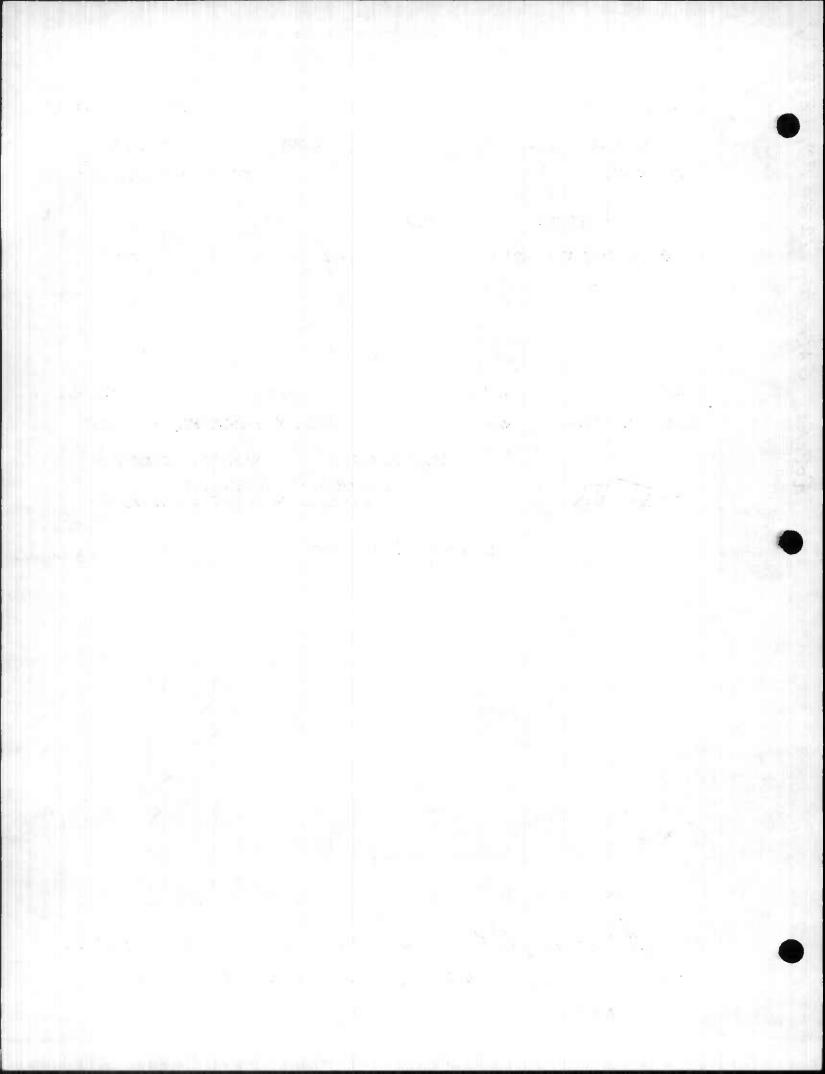
31. Date filed (Month, Day, Year)

AUG 31 1999

32. Registrar's Signeture

AUG 31 1999

34. Sparks

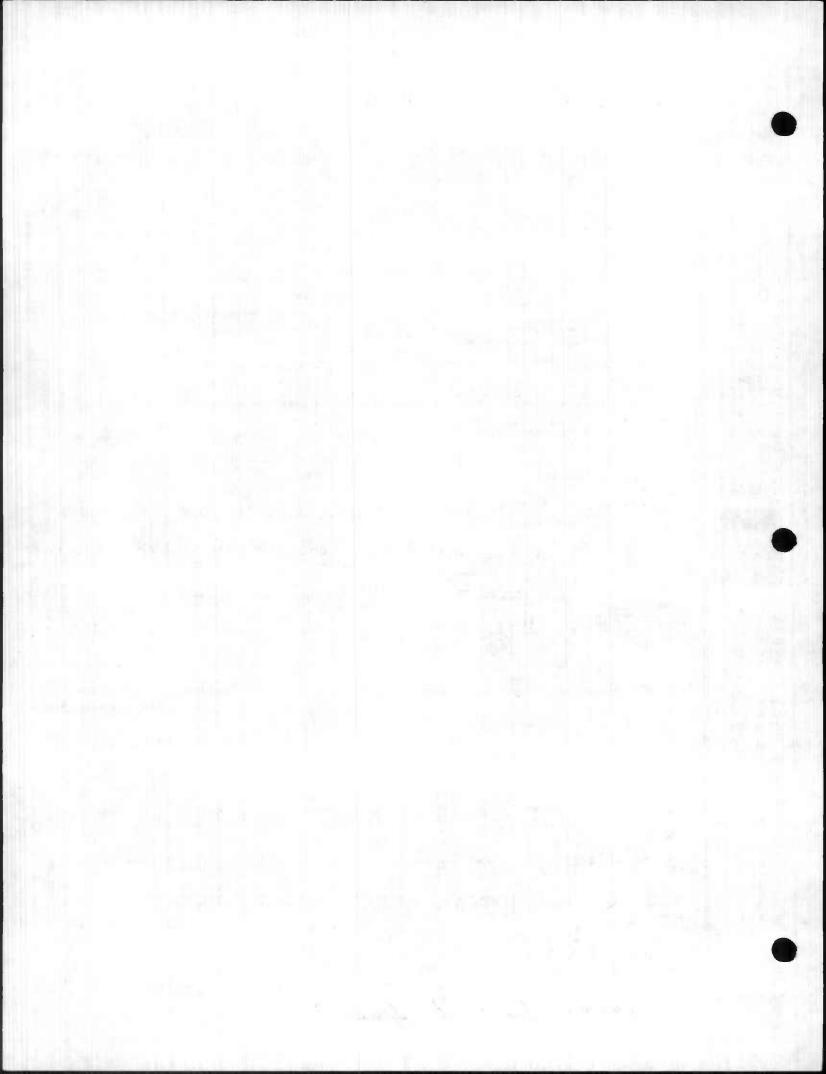


			Decedent's Neme (First, Mid				ertificate d	of C	Death	2. Date of De	Reg. No.		3. Tima of Death	
	Physicia: /Medica	n al	JOHN JA	MES		LAGH	ER	_		AUG	28 19	989	~ 1030/A	
	Examine		4e Facility Name (If not instituti 9625 Sea Shado		number)				o. City, Town, or I Columbia	Location of Deat		ward		
	Funeral Director		5. Social Security Number 180–34–4793	6. Sex 1X M 2 ☐ F	7. Age (In	yrs. last birthday Yrs.	Months De	eer eys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar. 31		9. Birthp Cour PA	olace (State or Foreign ntry)	
	Maryland H show Sed.at		Usual Residence of Decedent 10a. Stete 10b. Count MD Howar	1_		City, Town or L Columbia	ocation					1	0d. Inside City Limits	
	with the Ma a or 28a-f a Lbe notified	5	10e. Street and Number				10f. Zip Cod				10g. Citizen of		ntry?	
	urs sther death alf, or heme 23 Examiner must	by Funeral	9625 Sea Shado 11. Meritel Statua 1⊠ Never Married 2□ Me 3□ Widowed 4□ Divorce	12. Wea De Armed	21046 Decedent Ever in U,S. d Forces? es 2 ⊠ No				spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)		. Race - American Indien, Bleck, White, etc.		
1215-0	no. Nan *natum na Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT us					one du stired)	uring most of wor	king	16b. Kind of Business/Industry Social Security			
Maryland 21215-0020	E TOP	To Be Co	17. Father's Neme (First, Middle John B. Galla			11(1	gacion :		ecialist 18. Mother's Nen Alice	ne (First, Middle Loftus	, Maiden Sumar		ıcy	
111	and 2 show		19a. Informent'a Neme/Reletionship (Type, Print) Catherine Gallagher, sister 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State 7561 Broadcloth Way, Columbia, Md. 210-									1046		
Baltimore,	Tages 1 Imeni of H tant: if Ner jury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Maple Hill at Salem Crem								8/30/99 20c. Location - City or Town, State Archbald, Pa.			
	Depu Impo		21. Signeture of Funerel Service 23a. Part1. Enter the disease, a shock, or heart feilure. List	L Len	t caused the caused line.) W 5	555 Twin	ine a K	ral Home	d., Colu	mbia, M	id. 21	Approximate Interval Between Onset and Deeth	
100	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)		Due	to (or as e conse		ve	nous N	Malfor	matia	1	months	
	neit in	Examiner		261								1		
687	Pur pur	a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initieted events resulting in death) Last	0	perto	to (or as a conse	equence of):						months Years	
O. Box 687	t the death certificate be by the attending physicia lached for use as the bur	a	Cause (Disease or Injury that initieted events	6. Hy	Due t	to (or as a conse	equence of):	e give	n in Pert I.		tobacco use co Yaa 2□ No		Years of the cause of death?	
s, P.O. Box 687	es that the death certificate be igned by the attending physicial be deteched for use as the bur	by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	6. Hy	Due t	to (or as a conse	equence of):	a give	n in Pert I.	1 🗆		ontribute to	Years of the cause of death?	
Il Records, P.O. Box 687	ate has been signed by the attending physicial page 2 should be detached for use as the burn consistent to the bur	by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	6. Hy	Due t	to (or as a conse	equence of):	a give	n in Pert I.	1 24a. Was	Yaa 2□No	ontribute to 3 Pro-	o the cause of death? bably 4 Unknown ere eutopsy findings allable prior to mpletion of cause	
Il Records, P.O. Box 687	ate has been signed by the attending physicial page 2 should be detached for use as the burn consistent to the bur	be completed by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant condit 25. Was case referred to medic axaminer?	d. d. lone contributing to	Due to Du	to (or as a conse	quence of): quence of): underlying cause	a give	26. Place of Dea	24a. Was perfe	Yaa 2□No an eutopsy rmed? Yea 2 MNo one)	3 Pro	the cause of death? bably 4 Unknown ere eutopsy findings allable prior to mpletion of cause death? Yes 2 No	
of Vital Records, P.O. Box 687	After this certificate has been signed by the attending physicial funeral director, page 2 should be detached for use as the but has a funeral directors.	to be completed by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant condit 25. Was case referred to medic axaminer? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 2 Accident 3 Suicide 6 Couk	d	Due to Du	to (or as a conse	equence of): quence of): quence of): underlying cause ont 3 DOA of 28c. I	Other	26. Place of Dea	24a. Was perfo	Yea 2 No Yea 2 No Yea 2 No One) dence 6 Ott how injury occur	24b. Wave confirmed	the cause of death? bably 4 Unknown ere autopsy findings allable prior to mpletion of cause death? Yes 2 No	
Division of Vital Records, P.O. Box 687	or Attending Physicien: The law requires that the death certificate be interdeath. Nector: After this certificate has been signed by the attending physicial in by the tuneral director, page 2 should be deteched for use as the burnels.	Certification: 10 be completed by PhysiciaryMedical	Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant condit 25. Was case referred to medic axaminer? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 2 Accident inves 3 Suicide 6 Couk 4 Homicide Homicide Certify	d. d. d. d. d. d. d. d. d. d.	Due to Du	to (or as a conse	equence of): quence of): quence of): underlying cause ont 3 DOA of 28c. I	Other	26. Place of Deg **: 4 \(\) Nursing H at ?* (es 2 \(\) No 6, date and place	24a. Was performent of the control o	Yea 2 No Yea 2 No One) Idence 6 Ott how injury occur Street and Num. wn, State)	24b. Wave cood	bably 4 Unknown ere eutopsy findings allable prior to mpletion of cause death? Yes 2 No	
Division of Vital Records, P.O. Box 687	The Reportation Attending Proyecters: The law requires that the death certificate be in 24 hours after death. Certificate has been signed by the attending physicial pletaly filled in by the funeral director, page 2 should be detached for use as the burners of the control of t	redical certification: 10 be completed by Physician Medical	Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant condit 25. Was case referred to medic axaminer? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 2 Accident inves 3 Suicide 6 Couk 4 Homicide Homicide Certify	d. d. d. d. dons contributing to dons contributing to long contributing to d. d. d. d. d. d. d. d. d. d	Due to Du	to (or as a conse	ont 3 DOA of 28c. I M treet, factory, off th occurred at the occurred at th	Other	26. Place of Deg **: 4 \(\) Nursing H at ?* (es 2 \(\) No 6, date and place	24a. Was performent of the control o	Yea 2 No Yea 2 No One) Idence 6 Ott how injury occur Street and Num. wn, State)	24b. Wave confirmed Specific anner as s and due to	o the cause of death? bebly 4 Unknown ere eutopsy findings allable prior to impletion of cause death? Yes 2 No Yes 2 No Yes 2 No taled. o the ceuse(s)	

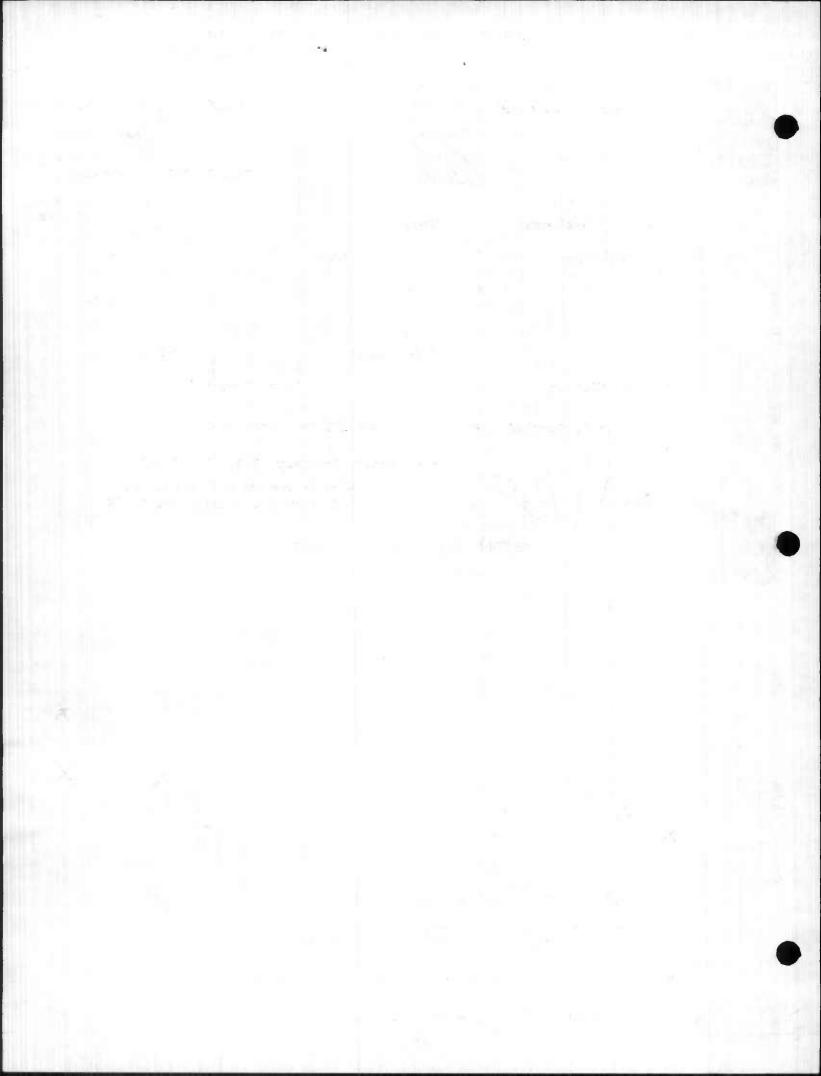
State Registrar

31. Date filed (Month, Day, Year)
AUG 3 1 1999

32. Registrer's Signature



7		1	1 December 11:	- (Fine 1414 "			Cei	tificate	of L	Jeath		Reg. No.			
	Physici /Medi		1. Decedent's Nem		M. Gerw	ig					AUGUS		1 999	3. Time of Death 06:15 Pt	
	Examir		4a. Facility Name (If not institution Joseph	n, give street end n n Medic	al Cer	iter		4	b. City, Town, or TOWS			y of Death Balt:	imore	
	Funeral Director		5. Social Security N	847	6. Sex 1 ☐ M 2 ☑ F		s. lest birthday) Yrs.	If Under 1 \ Months D	rear Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Di Jan. 16	ay, Year)	9. Birthp Coun Mar	lace (Stete or Foreign try) yland	
	show dat		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										16	0d. Inside City Limits	
	he Ma	Director	MD.		imore	ı	owson							1 ☐ Yes 2 🖾 No	
	with the or 2		10e. Street and Nu					10f. Zip Co		-		10g. Citizen of		try?	
	Jeath	Funeral	4 ECOW	ay Cour	12. Was De	cedenl Ever in	U.S. 13. \	1	286 t of Hi		pecify Yes or No	o- 14. Re	USA ce - Americ	an Indian.	
	72 hours after death with the Maryland natural, or thems 23s or 28s-f show deat Examiner must be nuffled at	by	1 Never Marr		Armed F	Forces? 3 2⊠No Give		Yes, specify		spanic Orlgin? (S n, Mexican, Puert Specify:	o Rican, etc.)	Speci	ack, White,		
	d within piene. r than	Completed	Eiementary/Seco		t grede completed	College (1-4or 5+)			ecedent's Usual Occupation Give kind of work done during most of workin ife. DO NOT use retired)					Business/Industry	
				12 Homemaker Own Ho 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme											
	d 2 should be filed the and Mentel Hyg	To Be	Eugene	Miche	tti					Lena	Lombard	li			
	2 sho and h la ma auma		19a. Informent's N	ame/Relationsh	nip (Type, Print)		19b. Mailir	g Address (S	treet e	and Number or Ru	ral Route Numb	er, City or Town	, Stete, Zip	Code)	
	ss 1 and 2 of Health a item 27 is other trai		Mr. Will		Gerwig/H	usband	4 Ec	oway C	t.	2B Tows			0% L T	0	
mit. Peges 1 and 2 should be filed within 72 hours aft partment of Health and Mentel Hygiene. portant: If Hem 27 is marked other than "natural", or pring trainmelic avent	permit. Peges 1 and Department of Health Important: If Nem 27 any Injury or other to		1X Burial 2	☐ Cremation	3 □Removai from	n State	cemetery, cren	netory or othe	r pleci		Date	20c. Location			
	artme ortant Injury		4 ☐ Donation 21. Signature of Fu	5 Other (Sp une al Servica L	~	Du	laney V	alley .Name end A			8-28-99	Timon	ium, M	ID.	
	pemit. Departr Importa any Inju		D X	1 1	PS	<		Ru	ck	Towson !					
Ī	777		23a. Part1. Enter t shock, or hea	he diseese, or	ormplications that	t caused the de	ath. Do not ente	er the mode of	f dying	York Rd g, such as cardiac	or respiretory a	nrest,	21204	Approximete Interval Between	
	Physician /Medical Examiner		Immediate Cause	(Finai			C BLAI							Onset and Deeth	
		-e	resulting in death)		u	Due to	(or as a conseq	uenca of):							
	cete be executed physician and s the buriel-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b	Due to	(or as a conseq	uence of):							
	Icete be executed physician and s the buriel-transit	edicai	Cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequenca of):												
	seath certific attending p				d										
	b death he atten	Physician/M	Part II. Other algnif	ficent condition	ns contributing to	deeth but not re	esulting in the ur	nderlying caus	e give	on in Part I.	23b. Dld	tobacco use co	ontribute to	the cause of death?	
	es that the de igned by the a be deteched i	by Phy									10	Yes 2□ No	3 ☐ Prob	Unknown	
	aw requir ss been s 2 should	Completed										en autopsy ormed?	ave	are autopsy findings sileble prior to appletion of cause death?	
	ate pag	Con									10	Yes 2 No	1□	Yes No	
	ysician: Th is certificate director, par	o Be	25. Wes case reference examiner?		Hospital: V	/		-5	Othe	26. Place of Dea					
	등 등 등	ition: To	27. Manner of Deat Netural Accident	•	28a. Dete	Inpatient 2 e of Injury onth, Dey Year)	28b. Time of Injury		Injury Work	4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
	i di di	Certification:	3 Suicide 6 Could not be determined 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)								281. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
	the Hospital thin 24 hours of the Funeral mpletely filled	edical (29a. Certifier (Check only one)	Certifying	Physician: To the Examiner: On the lend ma	e best of my kr basis of examin	nowiedge, deeth netion end/or Inv	occurred at the estigation, in	he tim my op	e, date and piace inion, death occu	, and due to the rred at the time,	ceuse(s) end m date and piaca	enner es st , and due to	ated. the cause(s)	
ì	vithin To the	Me	29b. Signature and	ticle of certifier	1			29c. Li	cense	number		29d. Date signed (Month, Dey, Yeer)			
			1		Sur	- 0	(0)	D 3	372	54		8/	26/	98	
			30. Neme and addr	ess of person v					то	WSON, I	1ARYLAI	ND 212	214		
	Sta Registr		31. Date tiled (Mon	th, Day, Year)	1 1999	Registrar's Sign	neture	-	-						



State of Maryland / Department of Health and Mental Hygiene 9 9 2 7 3

GROFF			Oldio Ol II	iai yiai		tificate			110 1110		Reg. No.			
Physic /Med		Decedent's Name (First, Middle, L RAYMOND W	GROFF							2. Dete of Deat Month AUGUST	Day	Year	9:20 PM.	
Examine		4a Facility Name (If not institution, g			4	lb. City, Tov	m, or Loca	ation of Death	4c. County	of Death				
		494 MIRABILE						DUND				LTIMORE		
Funera Directo		5. Social Security Number 212–36–0453	Sex 7. A	ige (In yrs. 6]	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day, uly 29	Year) 1938	9. Birthplace Country) Maryl	e (State or Foreign and	
2		Usual Residence of Decedent 10s. State 10b. County		100 Ch	y, Town or Lo	antina						1404	Anatola Ola Afrika	
Maryle	ctor	Md. Balti	more	100. OR	y, Town or Lo		ound	alk					Inside City Limits 1 ☐ Yes 2 No	
ter death with the Maryler flems 23s or 28s-f show	al Director	10e. Street and Number 494 Mirabile L	ane			10f. Zip (224		10	10g. Citizen of What Country? USA			
5-0020 72 hours after death with the Maryland natural", or flame 23a or 28a-f ahow after Evertice ment be notified at	by Funeral	11. Meritel Status 1 □ Never Merried 2 □ Merried 3 □ Widowed 4 ☒ Divorced	12. Was Deceden Armed Forces 1 N Yes 2 L If Yes, Give Year or Dates:	? No		Ves Decede I Yes, speci			in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		ck, White, etc. White		
21215-0020 d within 72 hours aft plene. In than "natural", or in the deciral frame.	Completed	15. Decedent'a E (Specify only highest gi Elementary/Secondary (0-12)	5+)				ation during most		16b. Kind of Businass/Industry					
d 21	Con	12th			I	iber	Opt	ic Te				T & T		
⊆ 239≥	To Be	17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla)												
- Z = N .		19a. Informant's Neme/Relationship (Type, Print) Patricia Groff / daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip C 125 Griffith Road Delta PA 17314										de)		
more, Pages 1 a ent of Heart if Nem ry or othe		20a. Method of Disposition 1 🖾 Burial 2 □ Cremetion 3 [4 □ Donation 5 □ Other (Spec		from State 20b. Place of Disposition (Name of cometery, cremetory or other place) Oak Lawn Cemetery 8/30/99 Baltimore Md.										
Baltimo		21. Signature of Funerel Service Lion	10	00		(onn	ss of Facility	Funer	al Home	e of Es	ssex		
Discoulation of the same of th		23a. Part1. Enter the disease, or conshock, or heart failure. List on	plications that ceuse	ed the death	h. Do not entr	er the mode	300 of dyin	Mace g, such as o	Ave ardiac or	Baltimorespiratory arra	ore Md.	21221 Ap Int	proximata ervel Batwaan aset and Death	
Physician /Medical Examiner		tmmediata Causa (Finat diseasa or condition resulting in death)	Arteri	oscle	rotic	Cardio	ovas	cular	Dise	ease				
P #	reul		b	Due to (o	r as a conseq	uence of):								
68760, tificate be executed g physician and es the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequence of):											
x 68760, artificate be exting physician a	Medical	that initiated events resulting in death) Last	d	Due to (or	r as a conseq	uence of):						1		
IS, P.O. BOX ss that the death cert igned by the attendin be detached for use	Physician/W	Part II. Other significant conditions		but not resi	ulting in the ur	nderlying ce	use giv	en in Pert I.		23b. Did to	bacco use co	intribute to the	e cause of death?	
S, P.O. ss that the igned by the be detache	by Phy									1 🗆 Ye	a 2 No	3 Probab	ly 4 XUnknow	
Ord requir	Completed b									24a. Was as perform	ned?	eveilal	autopsy findings ble prior to etion of cause	
The law	E									INSPE	CI'ION			
of Vital Rec hysician: The law his certificate has b		25. Was case referred to medical						OC Diese	of Dooth			101	es 2 No	
	To Be	axaminar? 1XXYes 2 No	Hospital:	iont 2	ER/Outpatien	t 3 DO/	Oth	or:		Check only on a 5 X Reside		ner (Graniki)		
Physical distribution		27. Manner of Death	28a. Date of Inj (Month, D		28b. Time of	-	Bc. Injun Worl		-	d. Describe ho				
Division or Attending after death. Director: After	Certification:	17 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on Diese of he		Injury	М	10	k? Yes 2□N		of. Location (St.	reet and Num	her or Dural D	oute Mumber	
Div		4 Homicide determined	28e. Place of Ir building, e	ng. (Specif)	y)	oot, rectory,	, omos			City or Town		ou or moral m		
Division or othe Hospital or Attending Phi rithin 24 hours after death. othe Funerel Director: After thi ompletely filled in by the funeral	edicai	29e. Certifier 1 Certifying Processing Check only one)	hysician: To the best miner: On the basis of and manner s	of examinat	wledge, death tion and/or inv	occurred a restigation,	it the tim	na, data and pinion, deetl	place, an	d due to the ca d at the time, de	ause(s) and meta end piece,	enner as state and dua to the	d a causa(s)	
To the within To the	Σ	29b. Signature and title of certifier	/			29c.	License	a number		25	9d. Date signe	d (Month, Day	r, Year)	

State Registrar

31. Data filed (Month, Day, Year) AUG 3 1 1999

J. Laron Locke M.D.

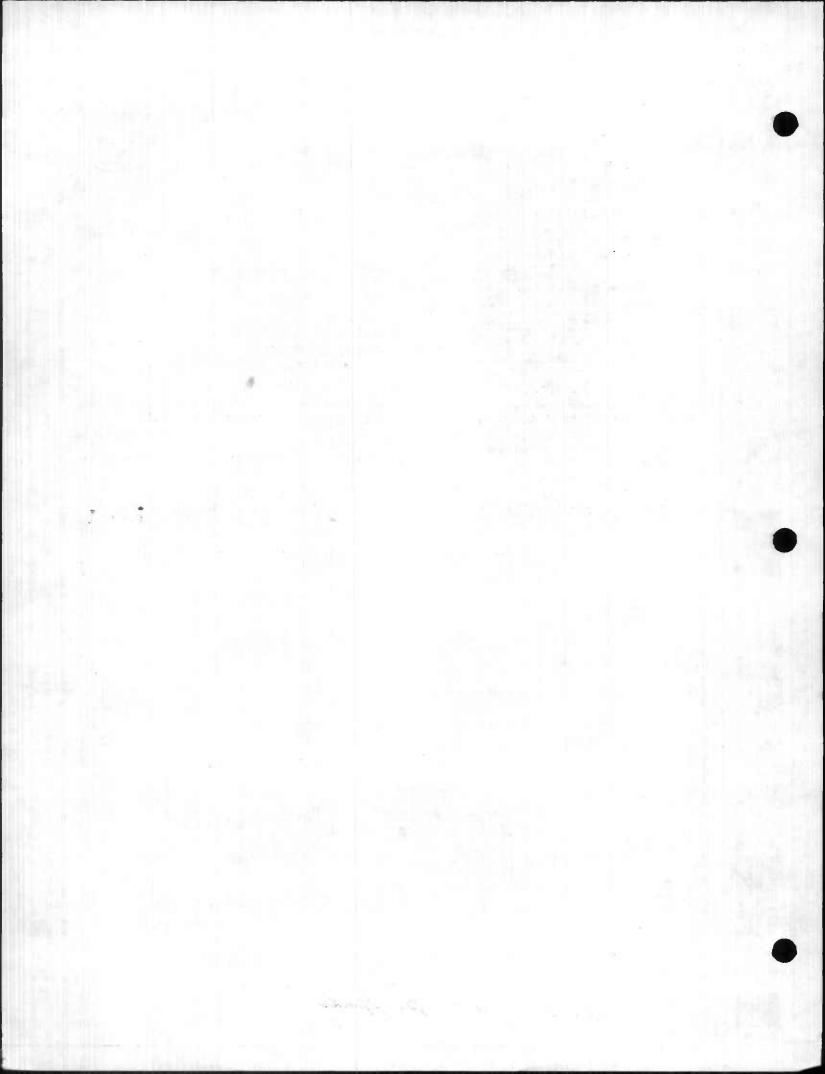
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Flegistrar's Signatura

DHMH 16 Rev 6/95

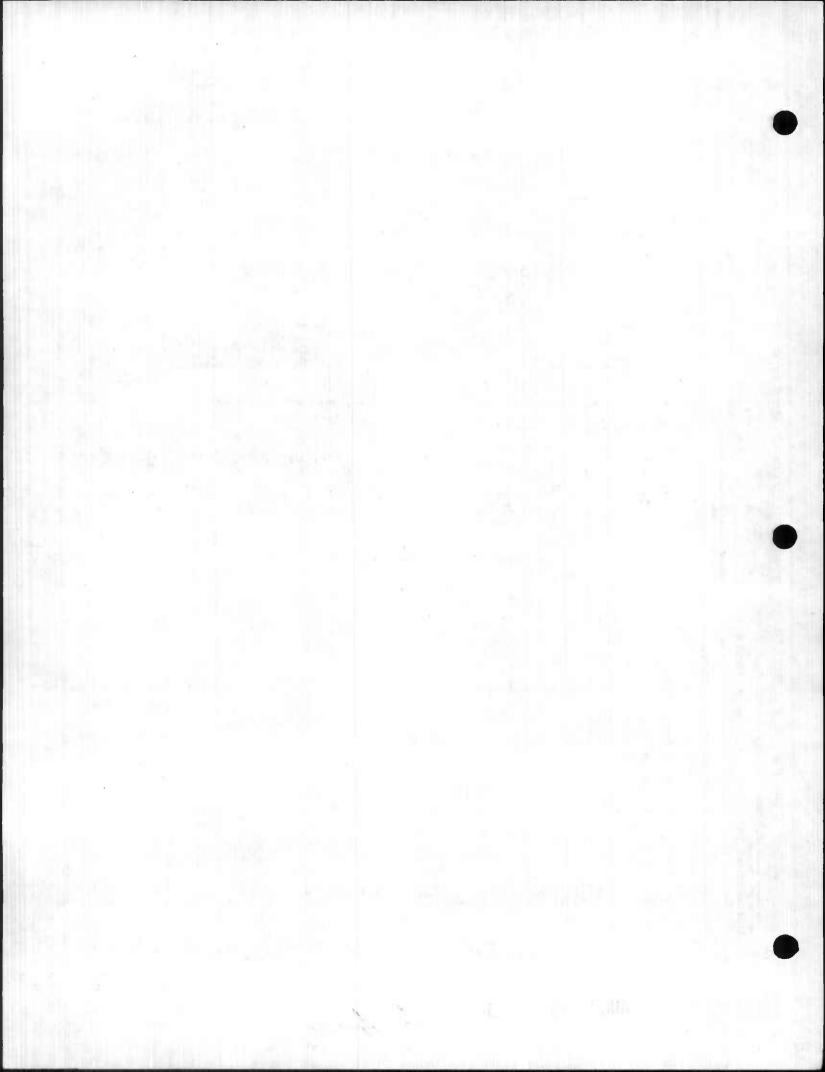
O.C.M.E.

AUGUST 27, 1999



State of Maryland / Department of Health and Mental Hygiene Q Q 27212

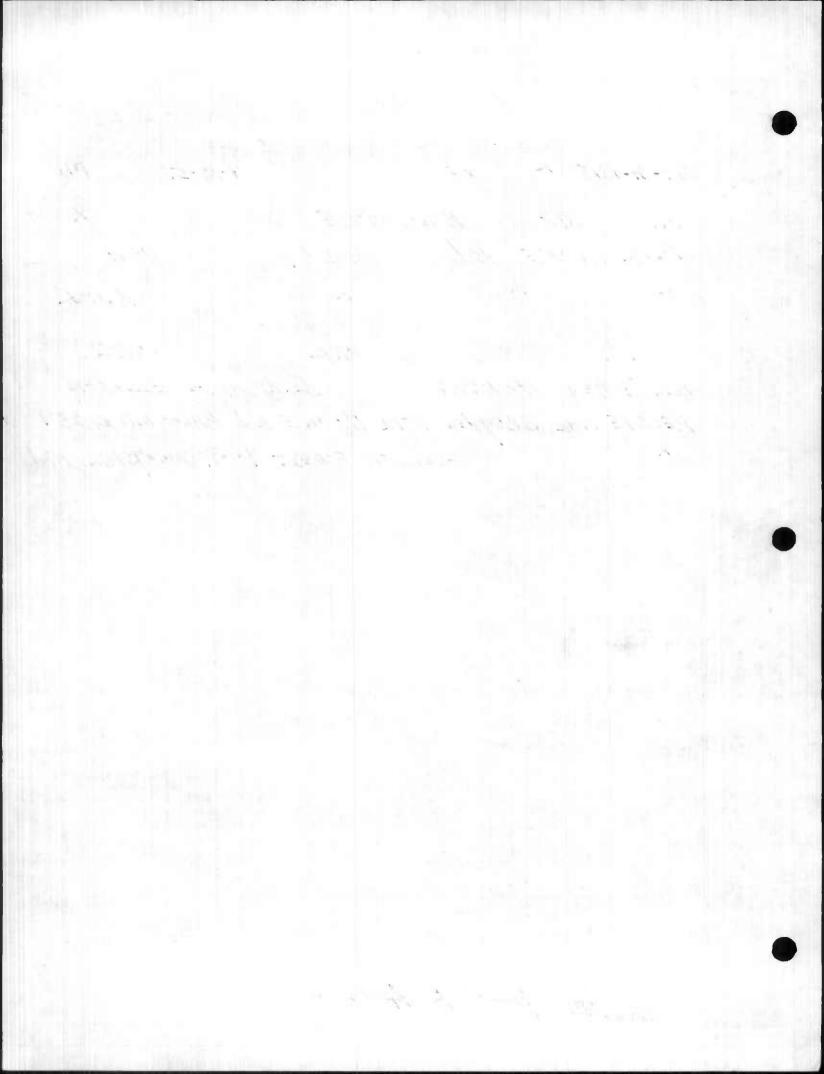
			(ertificate of	Death	P	leg. No.	61316		
		Decedent's Nama (First, Middle, Last)				2. Data of Dea	th	3. Tima of Death		
	Physician /Medical	Harold B. Harringt	on			August	27, 1999 Yaar	3:50am		
A	Examiner	4a Facility Nama (If not institution, giva street and number)			4b. City, Town, or	Location of Death	4c. County of Dea	ith		
		719 Maiden Choice Lane HR #	605		Catonsvi	lle	Baltim	nore		
	Funeral Director	176-14-3089 1□XM 2□F 8	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day July 25	9. Bir Cr 1917 F	ountry) Pennsylvania		
	2 .	Usual Rasidence of Decedent 10a. Stata 10b. County	10c. City, Town o	v I ocation				10d. Inside City Limits		
	at a serve			onsville				1 ☐ Yes 2 No		
	or 28s-f show be notified at	10e. Street and Number	Vac	10f. Zip Code		Ι,	0g. Citizen of What Co			
	The state of		505	2122	R		United St			
	flar death v r flams 23 siner must Funarral	11 Marital Status 12 Was Decedent Ev	ver in U.S.			pecify Yas or No-	14. Race - Ame			
21215-0020	e sur.	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Puart Specify:	o Rican, atc.)	Black, White	White		
2-0	72 ho matter fical	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occup	pation during most of wor	rkina	16b. Kind of Business	/Industry		
2	ed within 72 ho ygiene. ver than "naturi f, the Medical.	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done le. DO NOT use retire			77			
	Hygier of the Co.	12th	A	ssociate E				l Manufacture		
Ĕ	2205 0	17. Father's Name (First, Middle, Last)					Maiden Sumama)			
Š	T. Men	·	1		Frances		Roberts			
Maryland	d 2 sh h and 7 le m traum	19a. Informant's Name/Relationship (Type, Print)					r, City or Town, Stata,	Lie. MD21228		
	1 and Health em 27 fher tr	Mary L. Harrington/Wife 20a Method of Disposition	20b. Place of D	Maiden Cheisposition (Name of		Date	20c. Location - City or			
0	Pages sent of I int: if Its iny or or	MBuriat 2 ☐ Cremation 3 ☐ Removal from Stata	cemetery,	crematory or other pla	1					
Baltimore,	arthus Artent	4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licenses	Indiant	own Gap Ve		8/30/99	Annville,	Pennsylvania		
Ba	Dep Impo			Hubbard	Funeral H	Home, Inc				
		Quanta Or thomas	ha death Daned				·	cyland 21229		
ç.		23a Part 1 Enter the disease, or complications that caused to shock or heart failure. List only one ceuse on each line	ne death. Do not	enter the mode of dyl	ng, such as cerdial	or respiratory an	ast,	Approximeta tntarval Batween Onset and Death		
	Physician /Medical	Immediata Causa (Finat	C .	Λ -				2 11 14		
	Examiner	disease or condition rasulting in death)								
Ų,		Due to (or as a consequence of):								
	uted ansit	b. Clar	ue to (or as a cor				years			
Ć.	axe faltr	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying	++	isoquance orj.				1.0		
68760,	ifficate be assouted go physician and as the burla-transit	Cause (Disease or Injury that initiated events resulting in death) Last								
	- OF 0	resolding in death) cast				t .				
Box	th ce tendi	d								
0	ires that the death certisioned by the attending of be deteched for use a boy by should by Physician/M	Part II. Other significant conditions contributing to death but	not resulting in th	e underlying cause gi	ven in Part t.	23b. Dld to	obacco use contribut	e to the cause of death?		
9	that the sed by I detach				101	1 Yes 2 No 3 Probably 4 Unknown				
	po od									
Records,	: The law requires cate has been sign , page 2 should be Completed by					24a. Was a perfor	med?	Were autopsy findings available prior to		
ec	~ 40 00 -							complation of cause of death?		
	Page CO					1 D Y	as 2000	1 □ Yes 212 No		
/Ita	Attending Physician: or death. ector: After this certific by the funeral director, iffication: To Be (25. Was case referred to medical				eth (Check only or	18)			
5	hyal his c ai dir	1 Campation			4 LI Nursing F		ence 8 Other (Spe	acity)		
E	Ing P	27. Manner of Death 1 Natural 5 Pending 28a. Data of Injury (Month, Day)	Year) 28b. Tim			28d. Dascribe h	ow injury occurred			
S	tor: / the f	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	201 Leasting /C	treat and Alumber of E	Pural Bauta Alumbar		
Division of Vital	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp.	4 Homicide determined 288. Place of Injury		, street, factory, office		City or Tow	treet and Number or R n, State)	Jurar Houta Number,		
_	illed O	29a. Certifier 1 Certifying Physician: To the best of	my knowledge d	eath occurred at the ti	me data and place	and due to the c	suca(s) and manner a	as stated		
	To the Hospital within 24 hours of the Funeral completely filled	(Check only 2 Medical Examiner: On the basis of a one)	xamination and/o	r investigation, in my	opinion, deeth occu	irred at tha tima, o	lata and place, and du	a to the ceuse(s)		
	Me dithin	29b. Signature and title of ceptilier		29c. Licens	se number	1	29d. Date signed (Mon	ith, Day, Year)		
	F S F O	IM BOOK ME		147	000		tun it ?	27 1999		
		30. Nama and addrass otherson who completed cause of dea	th (Item 22=) (T-	ne Print)	007		· Lyword	7),,,,,		
		Philling CL 711 M	1 - 1 - 1	Chair	-	Cala	v allino	27, 1999 MD 21228		
	State	31. Date filed (Moont, Day, Year) AUG 3 1 1999	s Signature	1 ~1012	- ~ 072	Laron	12 JI	コレヘイムム		
	Registrar	AUG 3 1 1999	va /	9 1						
DHI	AH 16 Rev 6/95			sport	2					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner HOMEWOO 7. Aga (Irl yrs. last birthday) 40 If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Under Months 6. Sex 9. Birthplace (Stata or Foraign Country) **Funeral** Days 1 MM 2□ F Director Usual Rasidenca of Decedant 10a. Slala 10b. County 10c. City, Town or Location 10d. Inside City Limita Nems 23s or 28s-f short over must be notified at 1 Yas 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1512 filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forcas? 1 XYas 2 ☐ No If Yes, Giva panic Origin? (Specify Yes or No-Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 ☐ Married 21215-0020 6 1□ Yas 2XNo Specify: Completed by 3 Widowed 4 Divorced Yaar or Dates: 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry I Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 other treumatic avent, Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be finent of Health end Mental I ant: If Item 27 is marked of Me ELLISON 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) BALGO, MD 21239 R.09 8EN 15E55/E 20a. Mathod of Disposition 20c. Location - City or Town, Stata Department of H important: If Iter eny injury or off 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Enter the inches of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart feiture. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner by Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediala cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Dua to (or as a consequanca of): P.0. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown obstructive Division of Vital Records, 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Be Completed 2 No 1 Yas 2 No certificate 1 Yas To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical funeral director, 25. Was case refarred to medicat axaminar? 26. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3D DOA 28a. Data of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturat 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Pleca of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 ☐ Homleida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, deta and ptece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signalura and titla of opposite (60gw. MOUNT Loyal Ave, 30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

DALSHAN. 5. SAL-VIAMA: (60g w 282 Condistrar's Sign 31. Data filed (Month, Day, 1999) State AUG 3 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27 Aug. CHARLES 1999 9:11 a.m /Medical HARRIS 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Univ. of Maryland Medical System Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) **Funeral** 12M 2□ F Months Days /Yrs. 218-07-4588 Usual Residence of Decedent Director ss 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mentel Hygiene. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wes Decedent Ever in U.S. Armed Forces? 121 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indien. Black, White, etc. 2 No 1 Never Merried 2 Married 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0020 1□ Yes 2⊒No Specify: Black Completed by Specify: . 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) uckster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Bernedette Peges 1 end 2 should 2 Morris Harris 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 3 arns-wife 1603 Spr 20b. Placa of Disposition (Name of ennice tpartne Date extende 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges
Depertment of H
Important: If ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2,1999 Green mount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Doug 1955 Jun me Culloh 8 treet, Baltimore, MD. Plrt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, she c, or heart failure. List only one cause on each line. lton Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 20min. Cardiac Arrhythmia **Examiner** Due to (or es a consequence of): Physician/Medicai Examiner Intracerebral hemorrhage Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest Due to (or es a consequence of): ettending physician Arterovensus malformation The law requires that the death certificate be the t Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Xinknown peudis by 24b. Were autopsy findings avalleble prior to completion of ceuse of death? Completed 24a. Was en autopsy performed? certificate hes 20No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Mopatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred After t 5 Pending Investigation 1X Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide

Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu the Hospital

Certification: Medical

6 Could not be determined Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Ccrifying Phyalcian: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner as stated. (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of pertition

31. Date filed (Month, Day, Year)

P12446

29d. Dete signed (Month, Day, Year)

1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

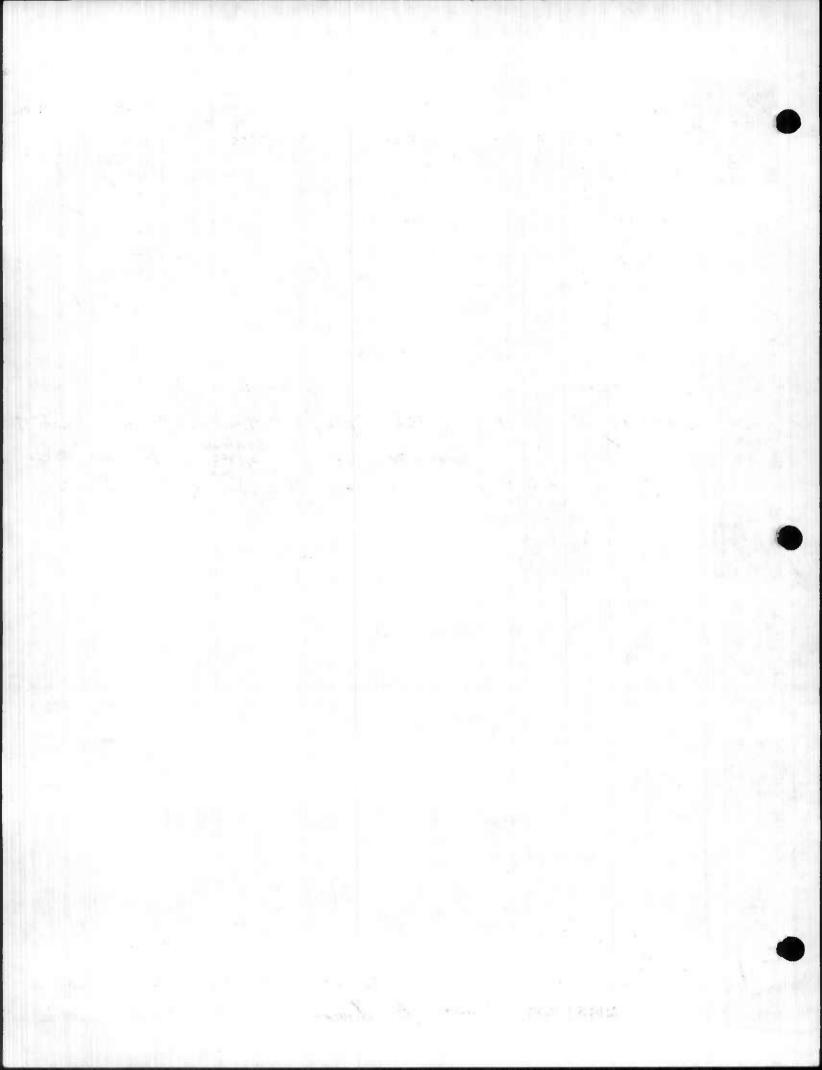
Waltender

Univ. of Maryland Medical System 22 S. Greene St. 32. Registrar's Signature

State Registrar

AUG 3 1 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death ant's Namh (First, Middle, Last) 2. Date of Death 3. Time of Death NIN EVON H 4b. City, or Location of Death not institution, give street and number) 4c. County of Death N/A 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Birthplaca (State or Foreign Country) 1X M 2 F Months Deys Hours Min. 42 220-66-6787 16, Maryland Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3709 Mt. Pleasant Avenue 21224 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 ☐ Never Married 2X Merried 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction Company 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Andrew Castello Beverly Walters 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Hendricks (Wife) 3709 Mt. Pleasant Avenue, Baltimore, Maryland 21224 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removel from State 8/30/99 4 Donation 5 Other (Specify) Green Mount Crematory Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee Marie 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or shock, or heart feilure. Line fautions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OK Due to (or as e consequence of) equence of) 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? 1 Tyes 1 ☐ Yes 2 No

Physician /Medical Examiner

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funeral

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s after death.

I Director: After to in by the funera

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Physician

/Medical

Examiner

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Completed

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Funeral

Director

r than "natural", or items 23e or 28e-f shorthe Medical Exerciper must be notified at

filed within 72 hours after Hygiene. Oher then "natural", or its

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other

Maryland 21215-0020

Baltimore,

Box 68760.

Division of Vital Records, P.O.

Examiner attending physician and for use as the burial-transit Physician/Medical use as f by 8 Completed

Be

Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Wes case referred to medical examiner? Hospital: 1 Yes 2 No 1 Supatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 SNetural 2 Accident 5 Pending investigation 3 ☐ Suicide

6 Could not be 4 ☐ Homicide

28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

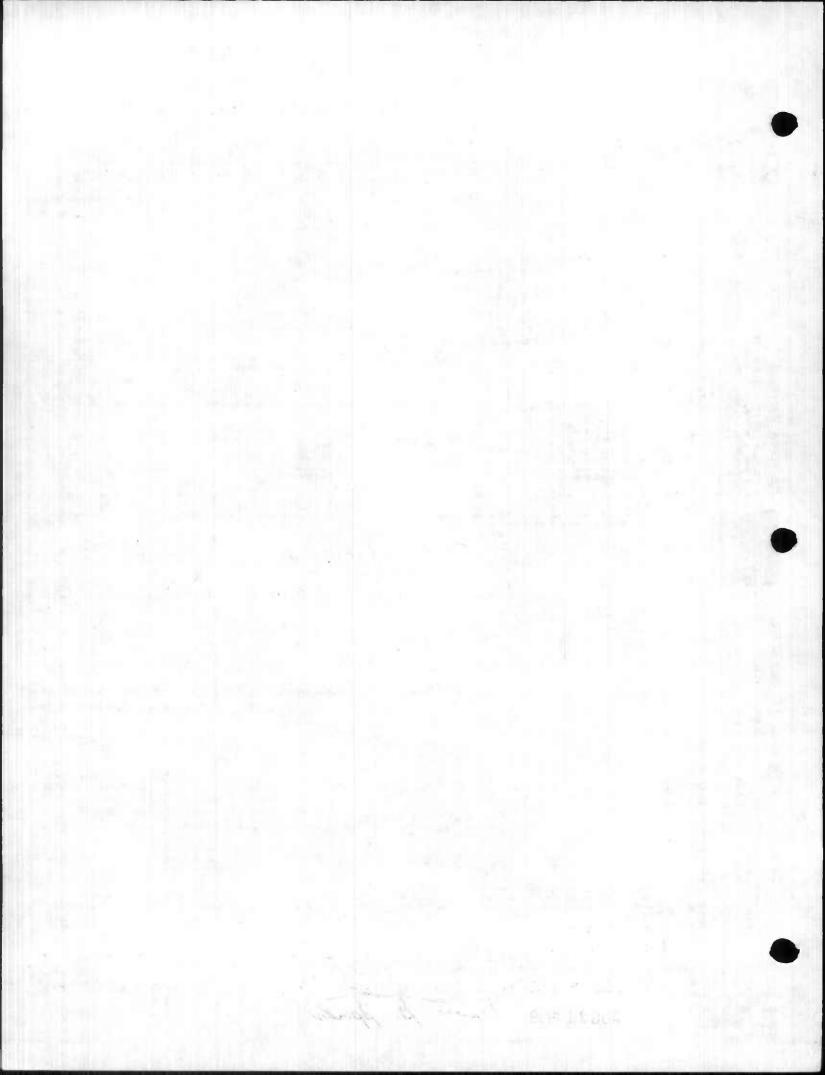
29b. Signature and title of

ed cause of death_(Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG31 32. Redistrar's Signat



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Irwm #7, per FH.08/31/99.gap.G774 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Ting Death Month AUG. 25, 1999 EDDIE Н. 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/a 7. Age (In yrs. lest birthdey) if Under 1 Year If Under 24 Hrs. Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1₽M 2□ F Months Days Hours 228-09-3786 87 86 Yrs. SEPT. 20,1912 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MARYLAND N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2627 KIRK AVENUE 21218 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes X No Specify: Special FRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 9TH N/A SANITATION AT BAKERY S AND H BAKERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ALFORD C. HOLMES MARTHA CHRETCHFIELD 19e. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) OZELLE HOLMES / WIFE 2627 KIRK AVENUE BALTO, MD. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from Stete ZION CEM. SEPT. 1,1999BALTO, MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 1412 E. PRESTON STREET BALTO, MD. 21213 Approximate Interval Between Onset and Deeth Immediate Cause (Finel RESPIRATORY FAILURE disease or condition resulting in death) SEPTICEMIA Due to (or as a consequenca of) Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? DE CUBITUS ULCERS 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DIS GASE 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Was an autopsy performed? CHEONIC REJAL FAILURE 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medicat **Examiner**

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death.

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within 24 hours or To the Funeral Completely filled

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Attending Physician:

Physician/Medicai

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Completed

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Certification:

Medical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medicai

Examiner

Funeral

Director

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28a-f

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Peges 1 and 2 should be 1 nent of Health end Mentai I int: If item 27 is marked or

permit. Peges 1 and 2 s Department of Health er important: If item 27 is any injury or other trau once.

The Medical Examiner must be notified at

Director

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Completed

Be

death with the Maryland

filed within 72 hours efter

21215-0020

Baltimore, Maryland

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 28 No

1 M.D.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Manner of Death Natural

2 Accident

3 Suicide

4 Homloide

5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Dey Year)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

28b. Time of

28c. fnjury at Work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner as stated.

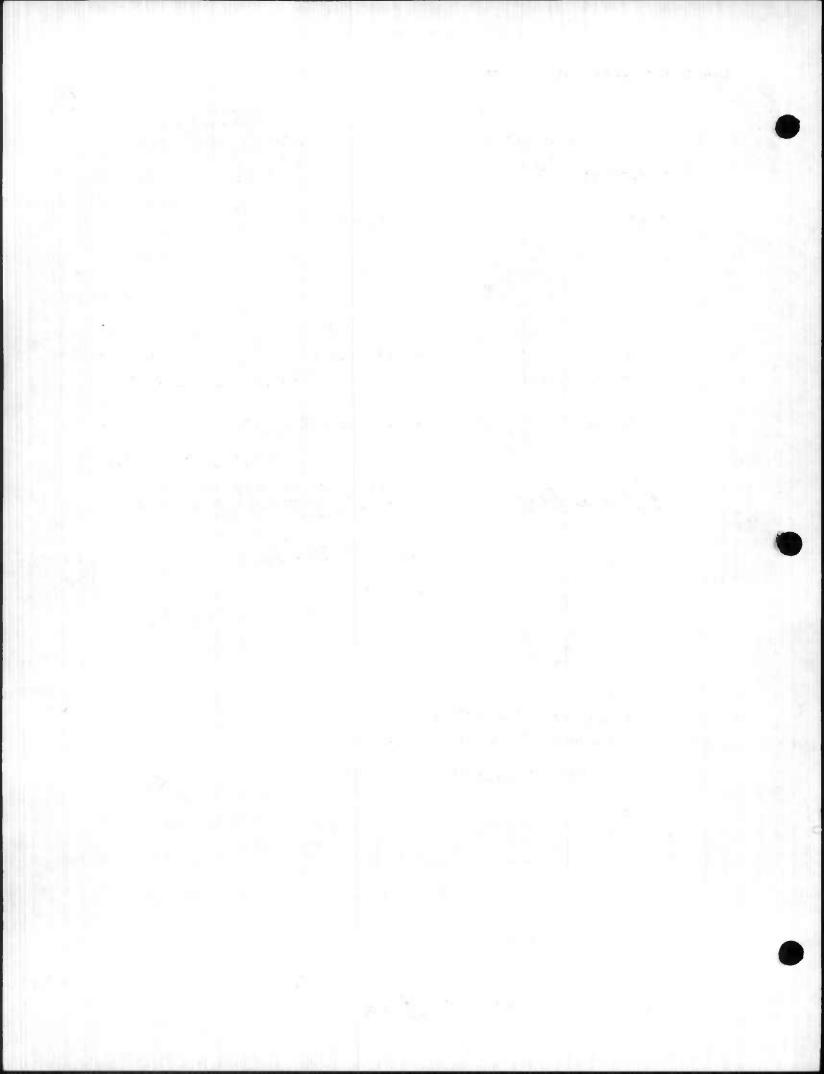
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D-22609 29d. Dete signed (Month, Dey, Year)

State Registrar

7445 FURNACE BLANCH PULLER BURNIETA 21060 REIDER M.D. 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

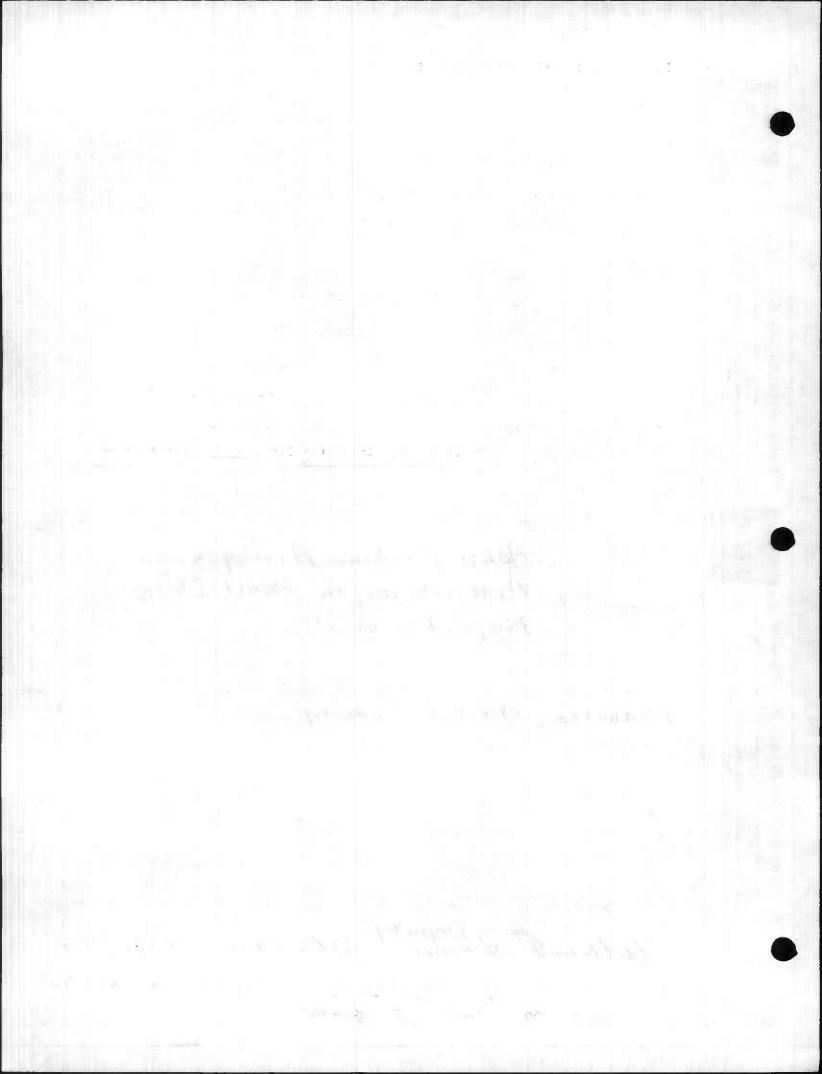
Amended Item#20b,20c perFH G775 9/20/99EVCertificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert. August 29, 1999 Laverne Hart 12:30 AM /Medical 4a Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 808 Bunch Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days XXM 2□ F Months Yrs. Director 571-48-3228 July 5, 1936 California Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits triban "natural", or items 23a or 28a-f ahov the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Funeral 808 Bunch Road 21060 S. A. 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Evar in U.S. Armed Forcas?

1 Yes 2 No
If Yes, Give
Year or Detes: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1958 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced 1979 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiena.
ant: If item 27 is marked other than ury or other traumatic event, the M. Elementery/Secondery (0-12) Coilege (1-4or 5+) Officer United States Army Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Denver Hart Catherine Roberte Morris 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Bunch Road Glen Burnie, Maryland 21060 Young Ja Hart (Wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other place)
Chesapeake Cremation Ctr 20a. Mathod of Disposition 20c. Location - City or Town, Stete 9/8/99 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Stevenson, Me Md. Department of Important: If eny Injury or Arlington National Cometery Fort Myer, Virginia 21. Signatura of Funaral Service Licensae 22. Name and Address of Facility Singleton Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Glen Burnie, MD 21061 Approximete Interval Beh Onset and Death **Physician** Immediete Cause (Final diseese or condition resulting in death) /Medical rrhythmin Examiner Due to (or as a consequence of): Physician/Medical Examiner teriosclerotic The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pertensión Box 68760. Due to (or as a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? norbid 1 Yes 2 No 3 Probably 4 Onknown by of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yas 2 00 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical axeminer? Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Nesidence 6 Other (Specify) 1 Ns 2 No 27. Menner of Death 28b. Time of 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier (Check only one) 29b. Signeture end title of certifier Deputy 29c. License number 29d. Date signed (Month, Day, Year) 0605 30. Name and address of person who completed suse of deeth (Item 23a) (Type, Print) 695 America JONES, mD le filed (Month, Dey, Year) 32. Registrar's Signature State AUG 3 1 1999 Registrar

AHIO



State of Maryland / Department of Health and Mental Hygiene 9 9 2 7 3 1 8

		ate of Death	Re	g. No.	61010					
Physician	Decedent's Name (First, Middle, Last) Joseph Michael Henry		2. Date of Death Month	Day Year						
/Medical	4a Facility Name (If not institution, give street and number)	4b. City, Town, o	August Location of Death	26 1999 4c. County of De						
Examiner	1616 B Forrest Avenue	Ft. Mea	ade	Anne Aru						
Funeral Director	5. Social Security Number 426-51-7881 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Mon	nder 1 Year If Under 24 Hr ths Days Hours Mir		Year) 9. Bi 1984 So	inholece (State or Foreign Jountry) uth Carolina					
yland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
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ar death with the Maryland them 23a or 28a-f show ther must be notified at 'unversi Director	10e. Street and Number 10f	Zip Code	10	g. Citizen of What C	Country?					
death w me 23a r.mast neral	1616 B Forrest Avenue	20755		USA						
	1 Never Married 2 Married 1 Tyes 2 12 No	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue as 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Bleck, Wh Specify:						
d 2 should be filed within 72 hours at a 22 should be filed within 72 hours at 12 standard other than "natural", or traumetic event, the Medical Examp To Be Completed by F	Elementary/Secondary (0-12) College (1-4or 5+)	Usual Occupation If work done during most of w Tuse retired)		6b. Kind of Business						
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2 should be and Menta is marked sumatic or		ress (Street and Number or F	-	City or Town State	Zin Code)					
2 5 66 6		orrest Avenue								
es 1 and of Health Herm 27 r other t	20e. Method of Disposition 20b. Plece of Disposition	(Name of		Oc. Location - City o						
Pages name of nrt: If the nry or o	Burial 2 Cremation 3 Removet from State 4 Donellon 5 Other (Specify) Carolina Men	orial Garden	08/30 N	. Charles	ton, SC					
permit. Pages 1 at Department of Nee Important: If them any Injury or othe ance.	Har Har	e and Address of Fecility desty Funeral								
-	23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart tellure. List only one cause on each line.	Ridgely Avenu mode of dying, such as cardia	ac or respiretory erre	Ils, MD 2	Approximata therval Between					
Physician /Medical Examiner	tramediate Cause (Final disease or condition resulting in deeth) a. Rhab down of condition a. Due to (or as a consequence)	nei			Onset and Death					
ficate be executed g physician and as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest b. — Due to (or es a consequence c. — Due to (or as a consequence consequence)									
25 00 00	d.									
at the death cert d by the attending elached for use. Physician/M	Part II. Other algorithms conditions contributing to death but not resulting in the underlying	ng cause given in Part t.	23b. Did tot	bacco usa contribu	ts to the causs of death?					
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aw requir			24a. Was an parform	autopsy 24b ed?	. Were autopsy findings available prior to completion of cause of death?					
F # 8 0			1□ Ye	s 250 No	1 Yes 2 No					
clan: sertific ector.	25. Was case referred to medical examiner? Hospitel:	Othors	eeth (Check only one							
T digital	27. Manner of Death 28a. Dete of Injury 28b. Time of	JUOA 4 Nursing	Home 5 Resider		ecity)					
tal or Attending Pins after death. al Director: After the din by the funeral certification:	27. Manner of Death 1 Naturel 5 Pending (Month, Dey Year) 28a. Date of Injury 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28c. Place of Injury at Work?									
3545	4 ☐ Homicide building, etc. (Specify) 29e. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occur	red at the time, date end place	City or Town,	use(s) and manner	es stated.					
he Hospin 24 house he Funer pletaly fill	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation and manner stated.	tion, in my opinion, death occ	curred at the time, da	te and place, and di	ue to the cause(s)					
To the Comp	29b. Signertifie tille of certifier; E. G. Lewn Edware C. J.	29c. License number VA	29	Aug 27, 1	nth, Dey, Year)					
(A)	30. Name and address of person who completed cause of deets (Item 23a) (Type, Print) Deot, of Pediatrics, Welter Reed Ame	wash DC	E GI	Tolum	of fr no					
State	31. Date filed (Month, Dey, Year) AllG 2 1 1000 32. Registrer's Signeture	vasn VC	CIGRENO	· Concent	I CTC, MC					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death August 26. Edith McCourt Harrington 12:45p.m. 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 2 Hampshire Woods Court Towson Baltimore Hours Min. B. Date of Birth-(Month, Dey, Year) March 7, 1907 5. Sociel Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Deys 1□ M 2□ F Vrs 216-46-3176 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2 No Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2 Hampshire Woods Court 21204 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bieck, White, etc. 1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐(No Specify: White Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Elementary School Teacher Baltimore City 17. Father's Name (First, Middle, Lest) 18. Mother'a Name (First, Middle, Meiden Sumeme) Charles J. McCourt Mary Ziegler 19e. Intormant's Neme/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Carolyn H. Wingate (Daughter) 1308 Maywood Avenue Towson, Maryland 21204 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bulaney Valley Memorial Gardens 8/30/1999 Timonium, Maryland 21. Signeture of Femiral Strice Ricense 22. Name end Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) erebr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 20 No 3 Probably 4 Unknown CAN Des V + Scel PIS 24b. Were autopsy tindinga available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2€No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical exeminer? 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home Pesidence 6 Other (Specify) 1 ☐ Yes 2 DNg 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28b. Time of 28e. Date of tnjury (Month, Dey Year) 28c. Injury et Work? 5 Pending Investigation 1 Neturat

Physician /Medical **Examiner**

Depertment of Health ar important: If Item 27 is any Injury or other trau

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Herris 23a

Pages 1 and 2 should be filed within 72 hours effer in nent of Health and Mentai Hygiene. Int: If Item 27 is marked other then "naturel", or Ite

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

Examiner -transit end physician er s the bunal-t

The law requires that the death certificete be executed Box 68760, Division of Vital Records, P.O. Hospital or Attanding Physician: After To the Hospital or minute within 24 hours effer death.

To the Funeral Director: Aftr

Physician/Medical þ Completed Be Certification: To

> State Registrar

2 Accident

3 Suicide

29a. Certifier (Check only one)

30. Neme end edd

4 Homicide

29b. Signature end title of certifier

31. Date filed (Month, Dey, Year) . ≥ 32. Registrar's Signeture

ess of person who completed cause of death (Item 23e) (Type, Print)

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

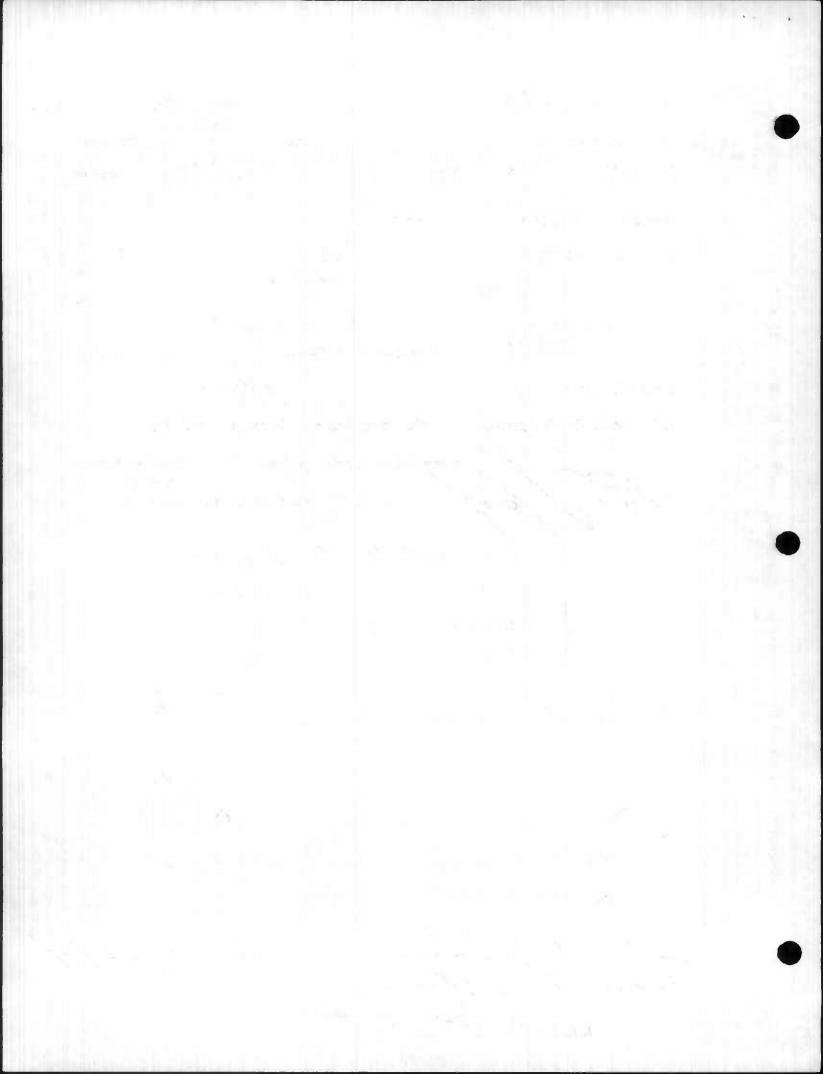
28d. Describe how Injury occurred 1 ∏ Yes 2 □ No

Location (Street end Number or Rurel Route Number, City or Town, Stete)

12 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

16006

6 Could not be determined

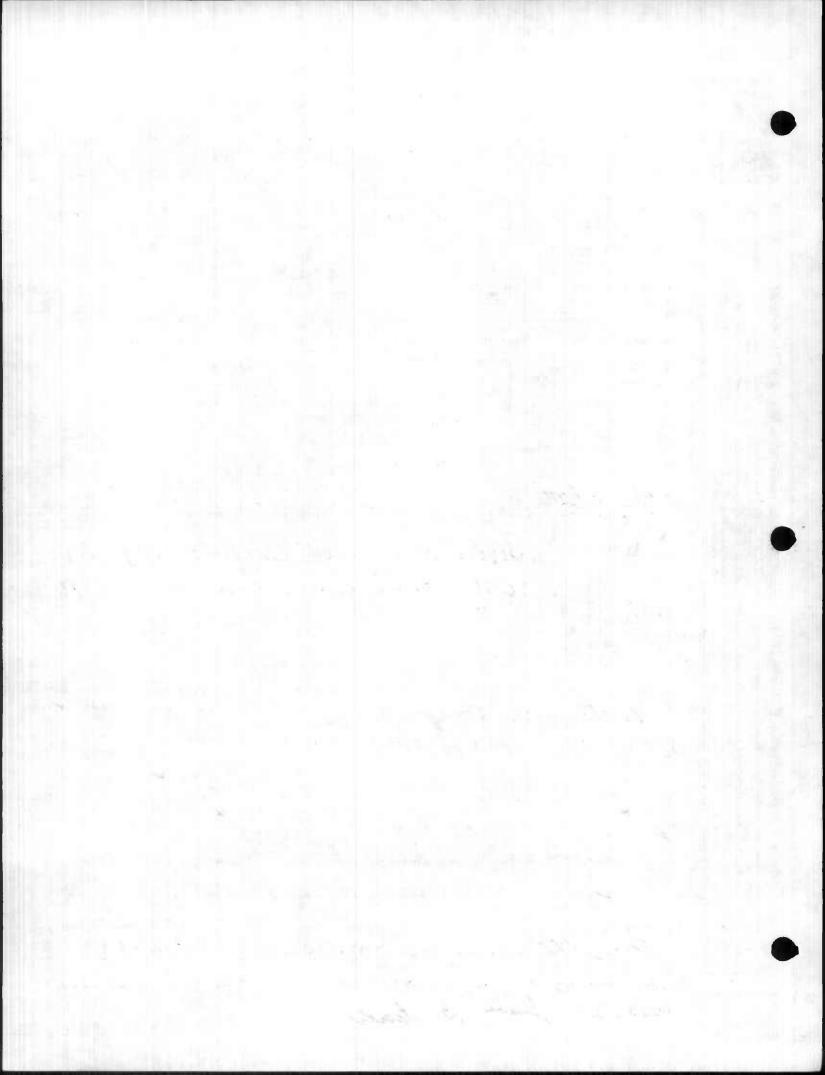


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 3. Time of Death 2. Date of Death Month Day **Physician** JOYCE LARRY Α. AUG. 25, 1999 7:41PM /Medical 4a Facility Neme (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 830 HARFORD COURT If Under 1 Year | If Under 24 Hrs.] 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Months Days Hours Min. Yrs. 47 FEB. 19,1952 MARYLAND Director 219-50-2273 **Uaual Residence of Decedent** 10a Stete permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once. 10h Count 10c. City. Town or Location 10d. Inside City Limits N/A 1 XYes 2 No Director BALTIMORE Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 HARFORD CT. U.S.A. 21202 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ Yo If Yes, Give Yaer or Dates: 14. Race - American Indian, Black, Whita, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2□ Married Specify AFRO-AMERICAN Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementery/Secondary (0-12) SECURITY GUARD SECURITY CO. 12TH 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E.RUTH PITTS LAWRENCE A. JOYCE 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS J. BARNES SISTER 5510 MIDWOOD AVE. BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removel from Stata 4 Donetion 5 Other (Specify) AUG.31,1999 BALTO, MD. ZION CEM. 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 21213 BALTO, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseesa or condition resulting in death) SEVERE HYPERTENSIVE CARDIONYOPATHY Examiner STAGE RENAL DISEASE Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? Records, P.O. the i signed by t 1 Yes 2 No 3 Probably 4 Vinknown VENTRICULAR TACKYCARDIA by 24b. Wera autopsy findings available prior to completion of cause of death? ADATIC PALVE REPLACEMENT 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral di 27 Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural the Hospital or Attending 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035706 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSP. BALDINOLE GHANDOUR AUG 3 1 1999 32. Registrar's Signatura State Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Physician MICHAEL **JANUSZESKI** JOSEPH AUGUST 28,1999 10:00PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 8. Data of Birth (Month, Day, Year)
Dec. 23, 19 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 6. Sex Birthplaca (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Yrs. Director 43 Oh. 164-38-5920 Usual Rasidance of Decedant with the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Yas 2 No Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? items 23a or death v 501 Belfast Rd. Funeral 21152 USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Was Decedanf of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, White, atc. filed within 72 hours after 1 Navar Marriad 2 Marriad 6 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: natural White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry I Hygiene. Francis X. Gallagher Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Workshop 17. Fathar's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental th, Important: If item 27 is marked oth any liqury or other traumatic event once. 18. Mother's Nama (First, Middle, Maiden Surnama) Be Francis J. Januszeski Helen Μ. Kruszelnitski 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Helen M. Januszeski/mother 2300 Dulaney Valley Rd. F005 Timonium, Md. 21093 20b. Placa of Disposition (Nama of comatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) Dulaney Valley Memorial 9/1/99 Timonium, Md. netura of Euneral Sarvice Licansaa 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwe Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in daath) MONTHS Examiner a ENDODERMAL SINUS TUMOR (YOLK SAC CARCINOMA) Physician/Medical Examiner that the death certificate be executed b. METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS FROM Due to (or as a consequence of): MONTHS Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury thaf Initiated avants rasulting in daath) Last ettending physician end for use es the bunel-tran P.O. Box 68760. DEHISCENCE INFECTED SURGICAL PROCEDURE Dua to (or as a consequence of) 98 MONTHS d HYDRONEPHROSIS LEFT KIDNEY been signed by the e should be detached Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown DOWN'S SYNDROME Records, by The law requires Be Completed 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy parformed? page 2 2 No certificete Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director; p. 25. Was casa referred to medical examiner? 26. Placa of Death (Check only one) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and placa, and dua to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. Medical 29a. Cartifiar

State Registrar 29b. Signatura and titla of cartifiar

30. Name and addrage

DHMH 16 Rev 6/95

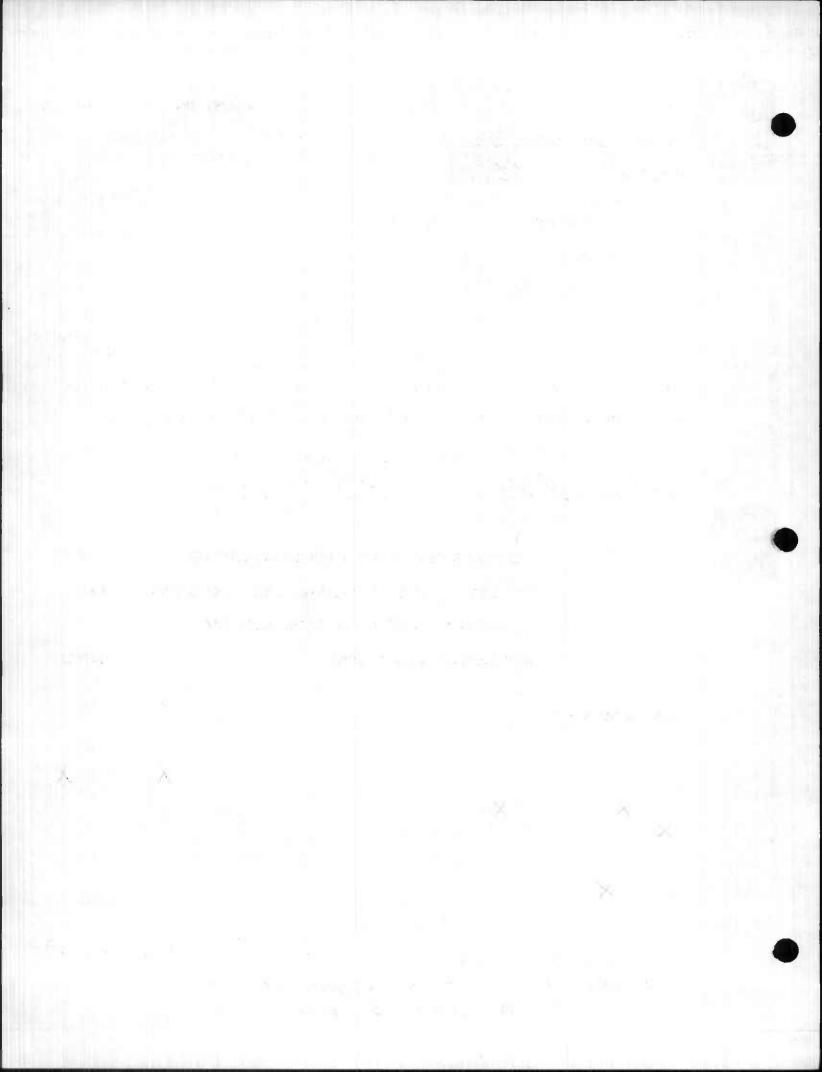
LILIA CEBALLOS, M.D. 7601 TOWSON, MARYLAND, 21204 OSLER DRIVE. 32. Ragistral stgnature 31. Data filed (Month, Day, Year) AUG31

(Item 23a) (Type, Print)

person who completed paus de

29c. Licansa number

29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: #12 PER F.H. G775 9-14-99 WR. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** :32 A.M 4b. City, Town, or Location of Death Jackson 99 James 210 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMONE
If Under 1 Year | If Under 24 Hrs. | 8. Dete o HARBOR NIA CITY HOS 8. Dete of Birth (Month, Day, Year) 5. Social Security Number vrs. last birthday) **Funeral** 10 M 2□ F Months Deys Hours Min 213-34-979 Yrs. Director Usual Residence of Decedent 10b County 10s State 10c. City. Town or Location 10d. Inside City Limits NA 1 Yes 2 No Himne Director 286.7 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 2 000 DOLIS Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispantc Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 √ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Black Baltimore, Maryland 21215-0020 b 1□ Yes 20 No Specify ğ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ment of Health and Mental Hygiere. ant if Item 27 is marked other than "1 ury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 10 th grade Salesman NA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William Bradford 10/0 Jackson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, Md Jackson Road Wite 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removel from State Department of Important: If any injury or 19-2-99 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet 22 Name and Address of Fecility of Funerel Service Ligensee ard Balto, Md ZIZIS Enter the disease, or corplications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart feilure. List only one cause on each line. grenne Approximate Intervel Between Onset and Death **Physician** /Medical Immediet Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 110 1 p (or es e consequence of): for use es Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 DOA 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day) 28d. Describe how injury occurred 28c. tnjury et Work? Division 5 Pending investigation 1 Neturat within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 Coutd not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) \$

State

DHMH 16 Ray 6/95

Registrar

31. Date filed (Month, Day, Year) AUG 3 1 1999

29b. Signature and title of certifier

AMSE

000 CalhEDRA 32. Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

ORIGINAL

29d. Date signed (Month, Dey, Year)

BALTIMORE, 4021201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** KATHRYN ELIZABETH KRAHLING 12:30 AM 30 AUG-457 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE MD / IT If Undar 24 Hrs. 8. Data of Birth Month, Day, Year) HOSPITAL ANNE ARUNDEL NORTH ARUNDEL If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M XXF 213.10.5211 Yrs. **Director** 2/18/12 MD Usuai Residence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryles ment of Health and Mentel Hygiene. Annual Franch Hygiene and the first 21s or 28s-4 show that if them 27 is an extend other than "natural", or frame 23s or 28s-4 show try or other traumatic event, the Medical Experiment to nother traumatic event, the Medical Experiment to an activities. 1 Yes 2 No Directo MD ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 N. HAMMONDS FERRY ROAD USA 21092 Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 2 X o If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc. 11. Marltal Status 1 Never Married 2 Married 1 Yas 2 700 Specify Specify: WHITE by 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Coilege (1-4or 5+) CAFETERIA WORKER ARA 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE THIRKELD CHANEY MYRTLE W. CHANEY 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE MAE BOSSOM - DAUGHTER 234 N. HAMMONDS FERRY RD., LINTHICUM, MD 21092 Department of Heal 20b. Piace of Disposition (Name of currently, cramatory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Buriai 2 Cremation 3 Removal from State GLEN MAVEN CEMETERY 9/1/99 GLEN BURNIE. MD 4 Donation 5 Other (Specify) Funeral Service Lice 22. Name and Addrass of Facility FINK FUNERAL HOME, PA Jugor 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061 KELLY GREGORY plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Onset and Death **Physician** /Medical Immediete Ceuse (Finel disaese or condition resulting in death) S TRUCTECH Examiner Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury P.O. Box 68760. HSDOM ZWAC Physician/Medical thet initieted events resulting in death) Last Due to (or as e consequence of) 60 USB 10 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. þ HOLOSCIENITAC CORCHARY ANTERY DISSASE 24b. Were autopsy findings available prior to eted 24a. Was an autopsy compiation of cause of death? certificate has lirector, page 2 s Comp ESCHEMIC CARDICHYOPATH 1 Yes 2 No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 ER/Outpetient 3 DOA Certification: To this funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? After injury 1 Neturel 5 Pending 1 Yes 2 No death. investigation 2 Accident efter death 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide a Euneral Dira Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and piace, and due to the cause(s) end menner as stated. | Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatura and wild of certifier 29c. License number 29d. Data signed (Month, Day, Year)

Registrar

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DAVSO

Russ, HD

AUG 3 1 1999

31. Date filed (Month, Day, Year)

me and address of person who completed cause of death (Item 23a) (Type, Print)

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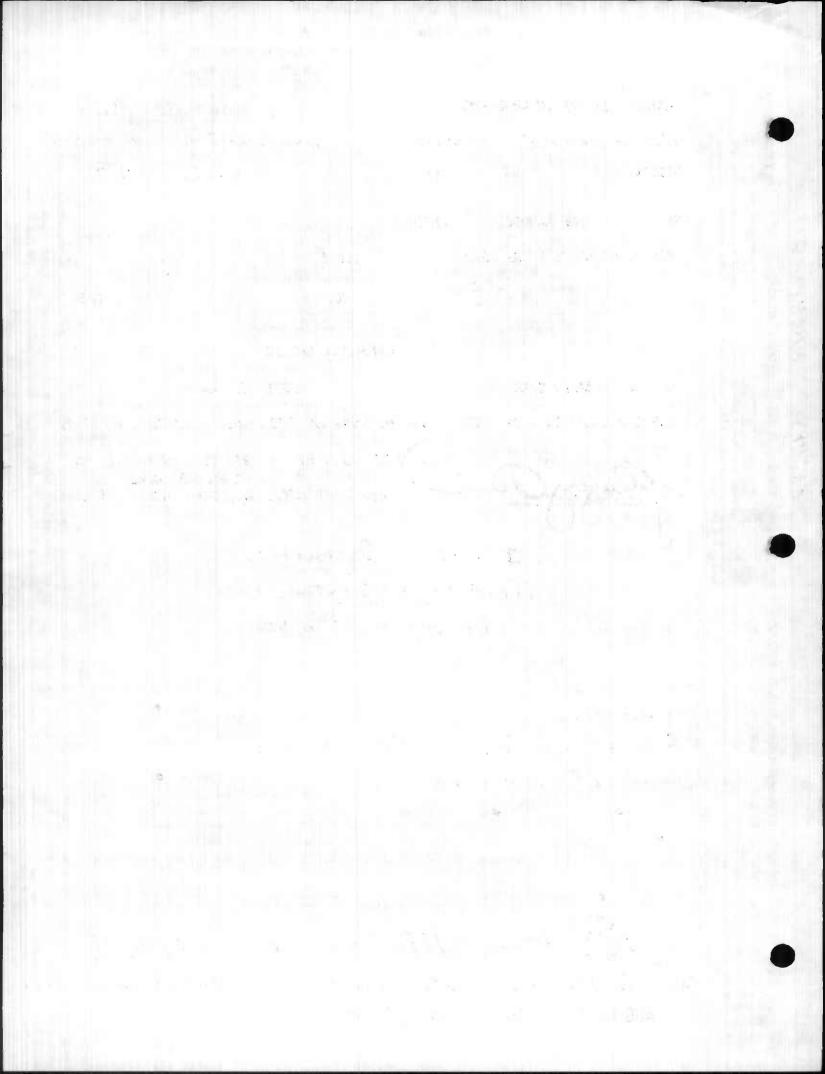
32. Registrer's Signature

200 Hosperac

Drive

GIFA BURASE PARYLAND 21061

PHRYN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** August 28, 1999 ocation of Death 4c. County of Deeth Manfred Kwasnik /Medicai 11:05 AM 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manor Care Ruxton Ruxton Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year July 18, 19 if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Min. Hours 120 M 2□ F Yrs 212-09-2579 85 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 K No Director Md. Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 204 E. Joppa Rd. #1202 21286 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 2 Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondery (0-12) College (1-4or 5+) Lawyer Self employed 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 Joseph Kwasnik Wachowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 University Place Mary K. Kwasnik/daughter Baltimore, Md. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/31/99 Towson, MD. 22. Name and Address of Fecility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) ler. UNG Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot) Physician/Medicai Due to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown à Completed 24b. Were autopsy findings aveiteble prior to 24e. Was en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 1. Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, signed by the attending physician requires that the death certificate be certificate has His After Athending death. I or Atland atlar death Director: /

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" ~ ... en finjury or other traumetic event.

Physician

/Medical

Examiner

the burial-tra

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page 2

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Medicai

29a. Certifier (Check only one) 29b. Signature and title of or

31. Dete filed (Month, Day, Year)

Division of Vital Records, To the Hospital within 24 hours a To the Funeral C

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.R. Rahnama, M.D.

AUG 3 1 1333

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29d. Date signed (Manth, Day, Year)

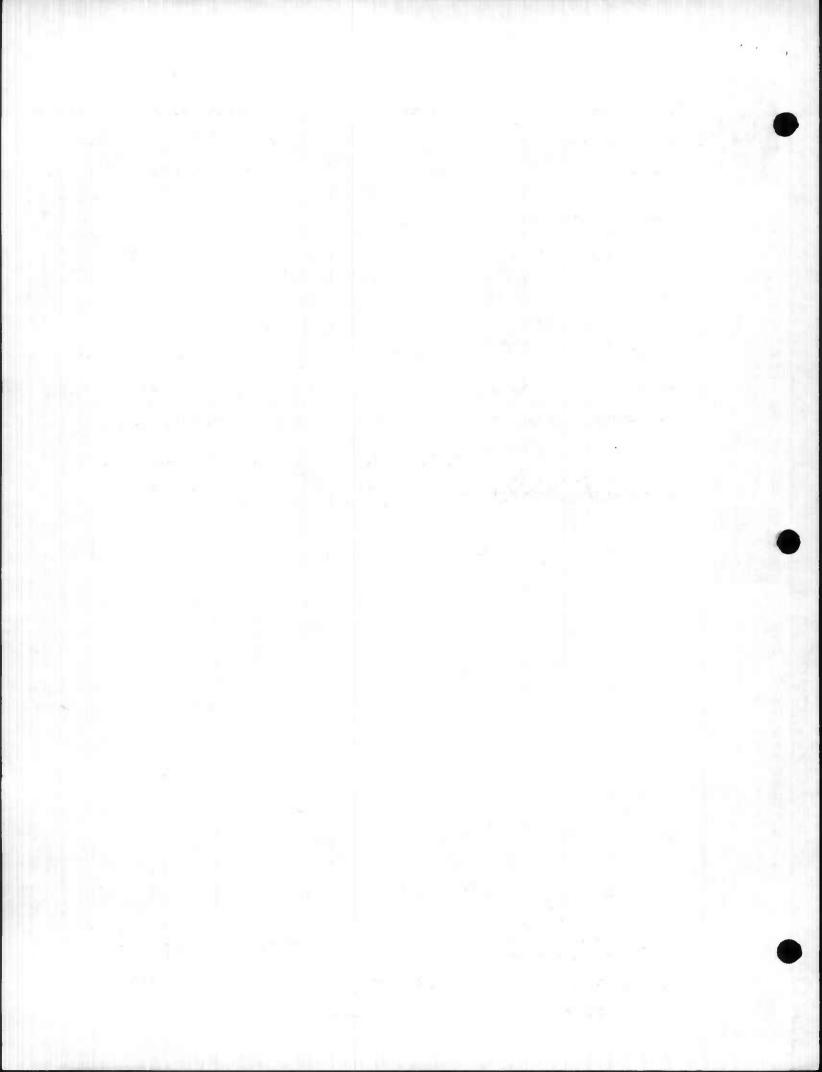
17 Fontana Lane Suite 105 Baltimore, Md. 21237

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the casis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29c. License number

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 58 **Physician** 08 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster 400 E. Main Street Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2ਊF Months Days Hours 89 Yrs. Director 212-70-3969 Germany June 3, 1910 Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Carroll Westminster 1 Yes 2 No MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 E. Main Street 21157 Germany Funeral death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. ifiled within 72 hours after de l'Hygiene. Black, White, etc. 1 Yes 2XNo If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If frem 27 is marked other tha any Injury or other traumatic avent, the LOGGE. 8 Homemaker Own Home 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) W. Heinrich F. Lamprecht Anna Tamm 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 212 Greenway, S.E., Glen Burnie, Maryland 21061 Mrs. Margret Kroll 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 8/30/99 Glen Burnie, Maryland ature of Fundatal Service Licensee 22. Name end Address of Facility Singleton Funeral Home, P.A., 1 Second Avenue, S.E., Glen Burnie, Md. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feilure. List only one ceuse on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel month disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 1 Yaa 2 No 3 Probably 4 Unknown signed bedet Records, þ 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed Deed completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No certificata of Vital Be 25. Was casa referred to medical 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. injury at Work? Certification: After Division Attending 1 Netural 5 Pending investigation 1 Tyes 2 No death. 2 ☐ Accident after death Director: An 24 hour.
The Funeral Dire.
Tilled in by the 3 ☐ Suicide 6 Could not be 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d Date signed (Month, Day, Year) 26385 Norman Goldstein, M.D. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) washington Height Medical Center Coestininstor,

F70

DHMH 16 Rav 6/95

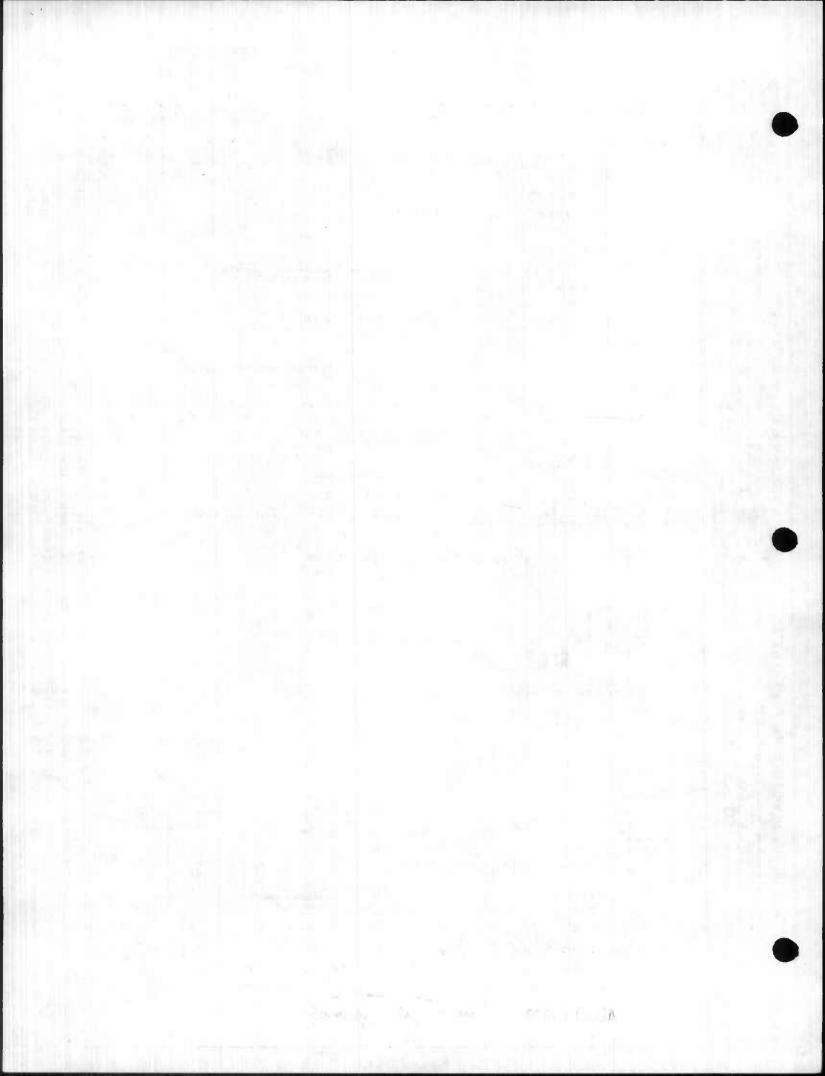
State

Registrar

31. Dete filed (Month, Day, Year)

AUG 3 1 1999

32. Registrar's Signatu



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Defe of Deeth 3. Time of Death **Physician** AUGUST 25 1999 JUNE P KIMMEL 8:05am /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Manor Care - Rossville Rossville Baltimore If Undar 1 Yaar If Under 24 Hrs. 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) May 31 1913 Birthplece (State or Foreign
Country) **Funeral** Months Deys Hours 1□ M 2X F 212-05-0246 86 Director Maryland Usuei Residanca of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore Eastpoint Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7808 Eastdale Road 21224 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yas, Give Yeer or Detes: 11 Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Naver Merried 2 Married 1 Yas 2X No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Telephone Operator 12th C&P permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Itam 27 is marked other any Injury or other traumer. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Edwards Margaret Becker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) / daughter Elaine Kiel 7808 Eastdale Road Baltimore Md. 21224 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial Gardens8/27/99 BelAir Maryland 21. Signeture of Euneral Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Essex er 300 Mace Ave. Baltimore Md. 21221 ations that caused the death. Approximete Intervel Between **Physician** /Medicai Immediete Ceuse (Fine) disease or condition resulting in deeth) **Examiner** Examiner non Sequentially list conditions, if any, leeding to immediate causa. Enfer Underlying Cause (Disease or Injury Due to (or as a consequence of) Physician/Medicai that initieted events resulting in deeth) Lest Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 2 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? Completed 24e. Wes en eutopsy 1 Yes ADNo 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 41 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3□ DOA 27. Mannar of Death 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation Naturel 1 Yas 2 No 2 Accident 6 Could not be 3 ☐ Suicide Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner stated. Medical 29a. Certifier (Check only 29b. Signeture add title of certifier 29c. License number
D - 38-754 29d. Dete signed (Month, Day, Year) MD assa

State Registrar

WASERM 32. Registrer's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

404. EASTERN BLUD, MD-21221

DHMH 16 Rav 6/95

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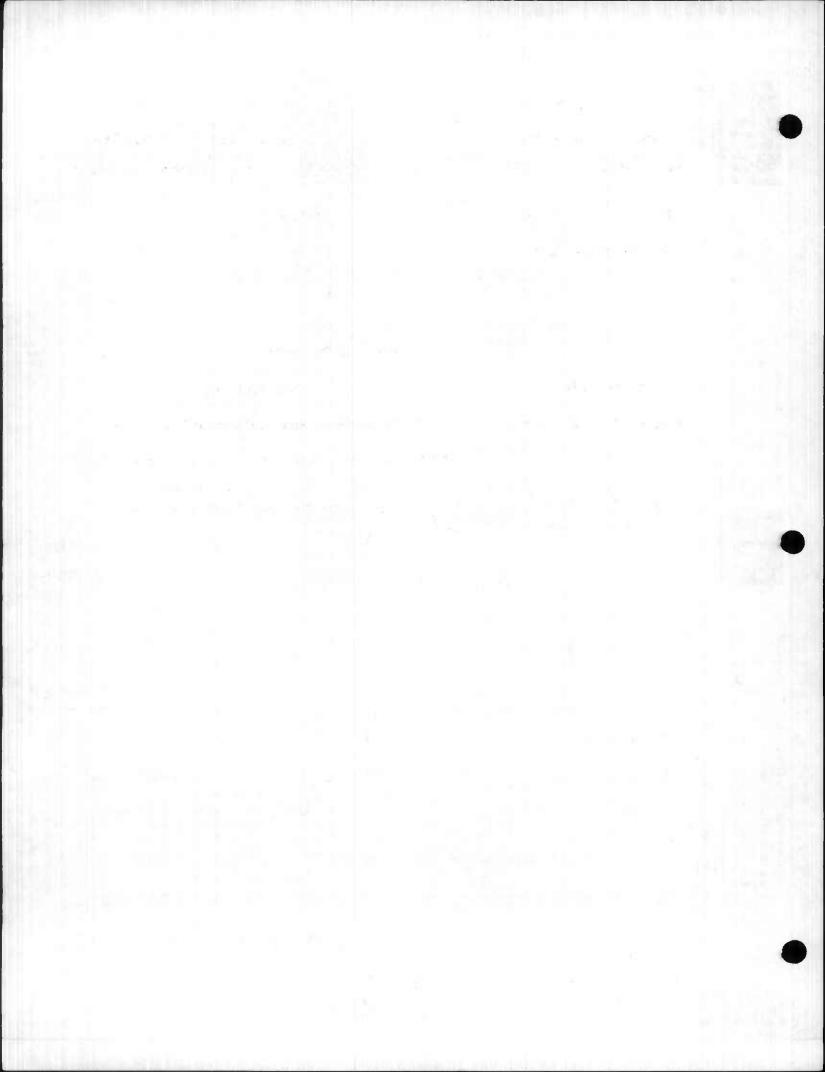
Baltimore, Maryland

Attanding Physician: The law requires that the death certificete be executed

Box 68760,

Division of Vital Records, P.O.

r than "natural", or itams 23a or 28a-f ahov the Medical Examiner must be notified at



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month GENEVIEVE KROSKI 26, 1999 4c. County of Death ugust :50 AN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosedale | Hunder 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 20, 192; Balt; more FVan Klin 5. Social Security Number ospital te 0 Sallare 9. Birthplece (State or Foreign Country) MARYLAND 7. Age (In yrs. last birthday) If Under Months Deys 1□M 200 F 217-16-6285 Sept. 76 30, 1922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3513 O'DONNELL STREET 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried Specify: WHITE 1 Yes 2 No Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER BENDIX CO. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ANTON MALINOWSKI BOGUSLAWA SCHUPARSKA 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3012 E. PRATT STREET, BALTIMORE, MD. 21224 MARY ADAMSKI/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEMETERY 8/30/99 BALTIMORE, MARYLAND 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings svailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 KNetural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide

The law requires that the death certificate be executed physician s the buriel Box 68760, Records, P.O. Division of Vital this funeral After

Hospital

within 2 \$

Examiner Physician/Medical ģ Completed or Attending Physician: Be Certification: To 24 hours after death. filled in by

Physician

/Medical

Examiner

Funeral

Director

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mportant: If Item 27 is

Physician

/Medical Examiner

Director

Funeral

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Completed

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29b. Signature and title of certified

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(Check only one)

aucreda

29e. Certifier

State

Registrar

DHMH 16 Rev 6/95

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

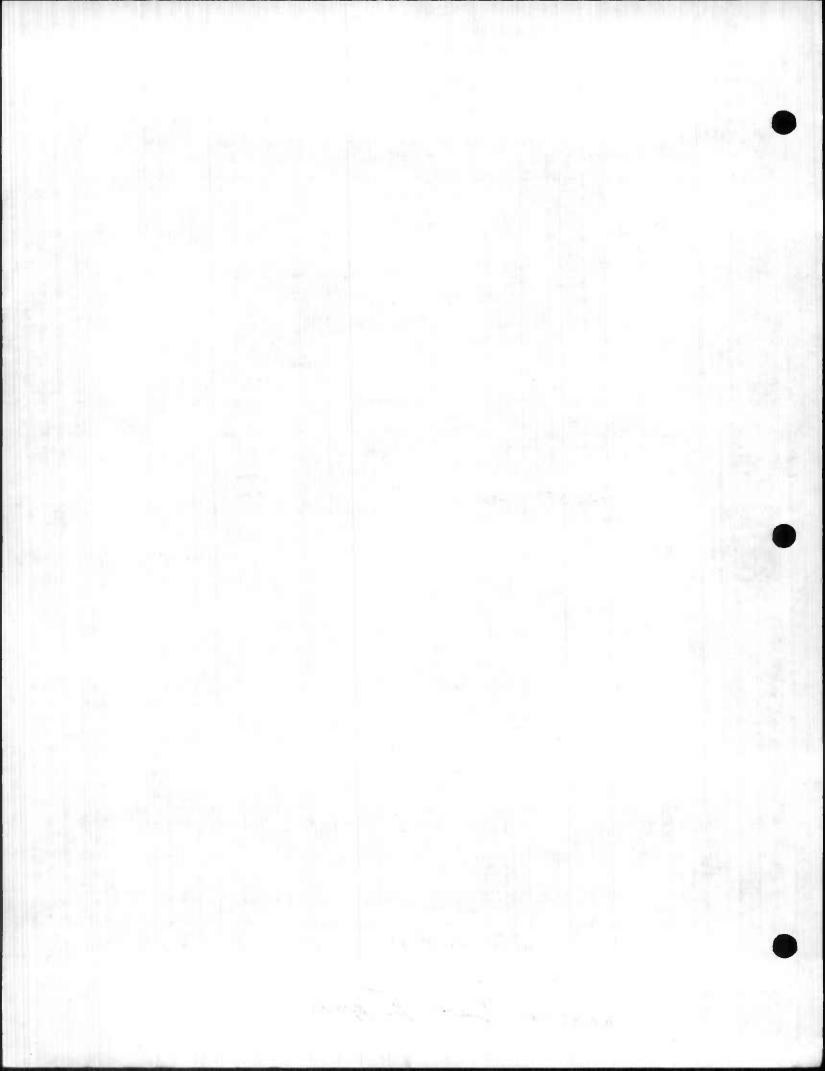
9000 Franklin Square Drive Baltimore Maryland 21237 MMers awanda 31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dus to the cause(s) and manner stated.

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Day **Physician** luguest PANDRA A. 8:30pm 26, 1999 LUCOT /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex PICE BACTO, Co. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F -30-66 Director 3 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov the Medical Examiner must be notified at 1. Yes 2 No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Norma 23a 2 ST 2/2 3 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forceş? 14. Race - American Indian. 11. Meritel Status Black, White, etc. filed within 72 hours after Hygiene. other then "netural", or the 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PuBLISHING EMPLOYED d 2 should be filed w th and Mental Hygier 7 is marked other th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be EDWIN LUCOT Peges 1 and 2 should MARTINO 19e. Informent's Neme/Reletionship (Type, Print), 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If Item 27 is any Injury or other trau BATTO Mp. 2/23/ CANETTE 191 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State BAUTO, TRO(4 ☐ Donation 5 ☐ Other (Specify) RCMALORY 21. Signature of Funeral Service Lopnage 22. Name end Address of Fecility DELLA NOCE +SONS complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Barto. Approximete Intervel Between Onset end Deeth Physician лиеціса tmmediate Cause (Finel disease or condition resulting in deeth) Month Examiner Examiner burial-transit that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 physician Physician/Medical the Due to (or es e consequence of): 980 P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes an autopsy parlormed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleisty filled in by the funeral director, t Be 25. Wes case referred to medicet axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Haspise Hospitel: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1. Netural 5 Pending 1 TYes 2 TNo Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner steted. Within 2

State Registrar Rile 4

29b. Signeture end title of certifier

Charles Sr. Balto 32. Begistrar's S

30. Name and address of parson who completed cause of deeth (Ijim 23a) (Type, Print)

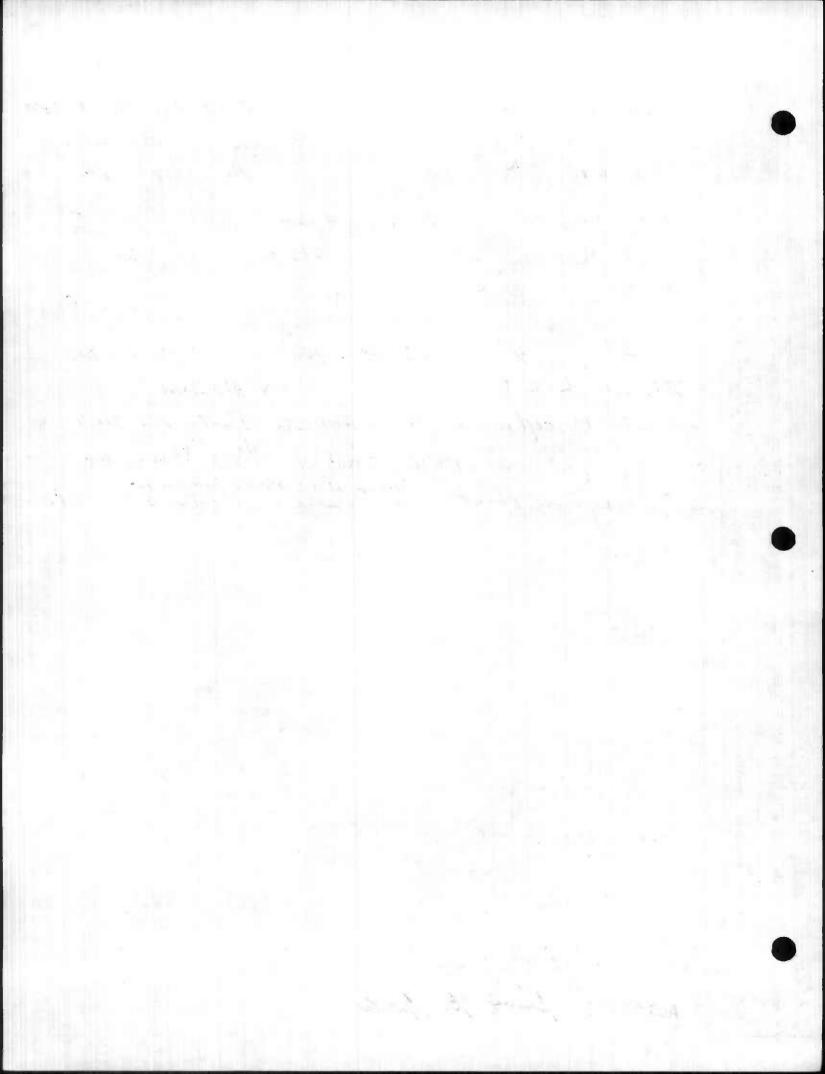
27,1999

29d. Date signed (Month, Day, Year)

29c. License number

225205

and

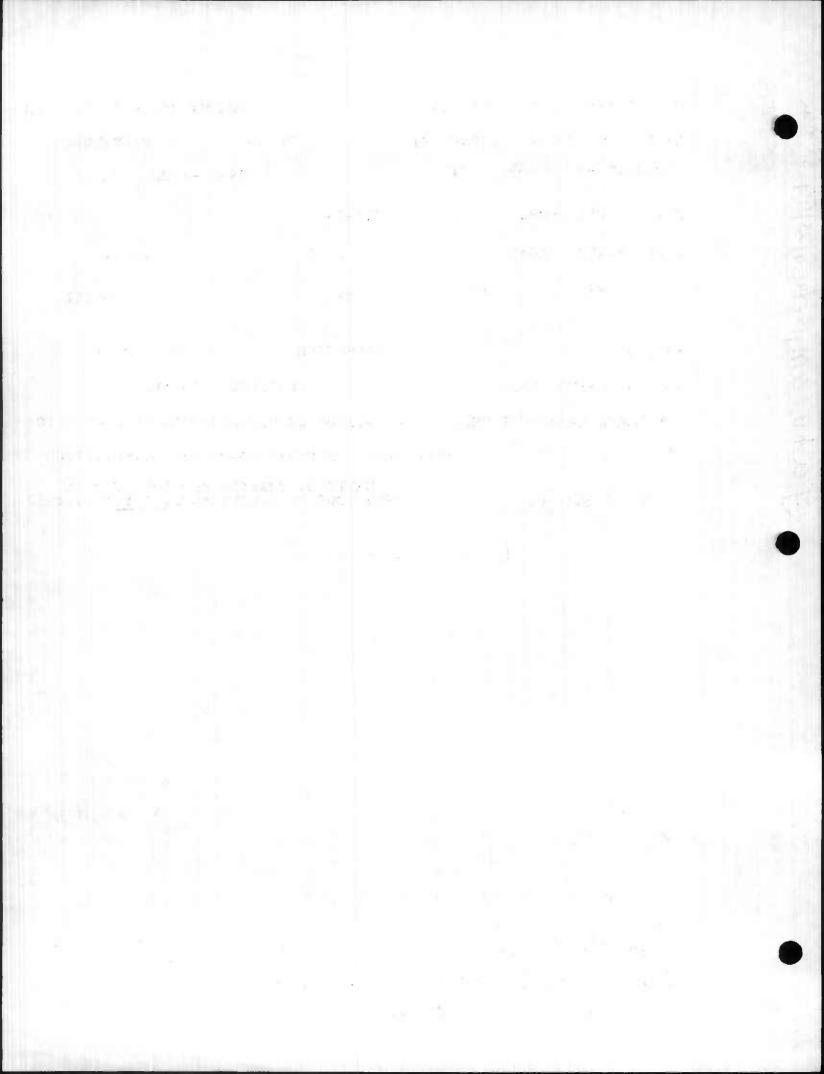


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month BETTY LAKE LANAHAN AUGUST 28,1999 8:30 AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER (HOSPICE) TOWSON BALTIMORE 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1 M XX F 220-46-7984 77 Yrs Director 04-01-1922 CHILE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD. BALTIMORE RUXTON Director 1 ☐ Yea X XNo 289-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 1901 RUXTON ROAD 21204 Нате 23а U.S.A. Funeral 12. Was Decadent Ever in U.S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian, Black, White, atc 1 □ Yas XXVo if Yes, Give Year or Dates: 1 Never Married X2X Married natural, or 1 ☐ Yes XXNo Specify: WHITE by Specify: 3 ☐ Widowed 4 ☐ Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 12 YEARS 17. Father's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) and Mental marked ARTHUR CAIRD LAKE RUSSELL FLORENCE 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W.WALLACE LANAHAN (HUSB.) Ibams 27 1901 RUXTON ROAD, BALTIMORE, MARYLAND, 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cramation 3 Ramoval from State Important; If GREEN MOUNT CEMETERY 09-01 BALTO., MD., 21202 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses me and Address of Facility
HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai 1M 9 CMCEr Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of) Box 68760 Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o ۵ 1 Yas 2 No 3 Probably 4 Unknown by Division of Vital Records, 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 8 Mother (Specify) Hospice 1 Yes 2 No Certification: To 3□ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 28, 1999 mo 30. Name end address of person who complyed cause of death prem 23a) (Type, Print) W. A. Riley Balto. md 21204 6-BMC N. Charles 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 1999 Registrar

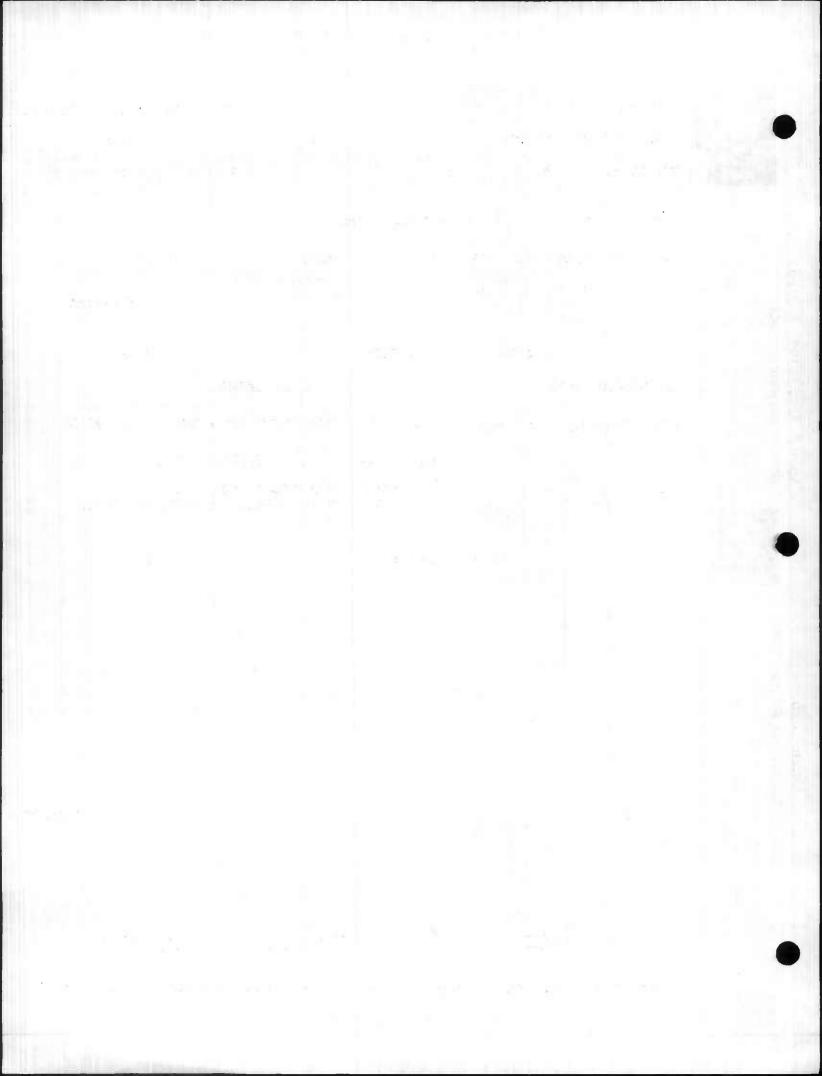
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DHMH 16 Rev 6/95



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	Physic		Decedent's Nem JUAN S	e (First, Middle, Li 5 - LAZO				2. Date of Da Month AUGUST	Dey Year 26 1999		3. Time of Deeth 7:00 P.				
	/Medi Examir		A ST THE ALL SECTION AND ADDRESS OF THE ADDRESS OF							4b. City, Town, or L	Location of Death 4c.		c. County of Death BALTIMORE		
Ī	Funeral Director		5. Social Security N 072-12-4		Sex NM 2□ F	7. Aga (In yrs. last birthdey)			ndar 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Data of Bir (Month, Da 12/24/	th	9. Birtho	9. Birthplace (State or Foreign Country) PHILIPPIANS	
	pug *		Usual Residence of 10a. Stete	f Dacedant 10b. County		10	o City Tou	m or Location						104 5-14-05-11-5-	
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21215-0020	d within 7. giena. er than "n	Be Completed		College (1-4015+)				(Give kind of life. DO NO MAITRE	dent's Usual Occupation kind of work done during most of working DO NOT use retired) TRED 16b. Kind of Business/Industry RESTAURANT						
pu	be filed tel Hygi d other event, t	Be (17. Father's Name							18. Mother's Nem		Maiden Sum	eme)		
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ox 68760,	Physician parameter per strength cardificate be associated attending physician and a for use as the burlet-transit	vMedical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list confirming in any, leading to limit cause. Enter Under Cause (Disease or that initieted events resulting in death) I	nditions, nmediate rhying Injury	b	Due	to (or es e	consequence	of):					Onset and Deeth	
. Box	0 0 2	siclar	Pert It, Other signifi	Icant conditions	contributing to	death but no	ot resulting la	n the underlyin	n causa ni	ven in Pert I	23h, Did t	obacco use c	ontribute to	the cause of death?	
P.0	thet the de led by the a detached f	' Physiclan/M		Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the state of the state				
Records,	aw requires ss been sign 2 should be	Completed by									24e. Wes	an autopsy med?	av	ere eutopsy findings alleble prior to implation of cause death?	
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Division of Vital	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completaly illied in by the funeral director.	Certification: To	1 Yes 2 No							4 Li Nuising mo	er: 4 Nursing Home 5 Rasidence 6 Mother (Specify) HOS] y et 28d. Describe how injury occurred			M Hospice	
Divis	or Atte	ertifle	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (S City or Tox	Street end Nur vn, Stete)	nber or Rura	al Route Number,	
	To the Hospital or within 24 hours efter To the Funeral Director Completaly filled in	edical	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) end menner as steted. 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause end manner stated.									teted. o the cause(s)			
	Withi To th	2	29b. Signature and	9b. Signature and title of certifier 1						43725		29d. Date signed (Month, Day, Year) 8/27/79			
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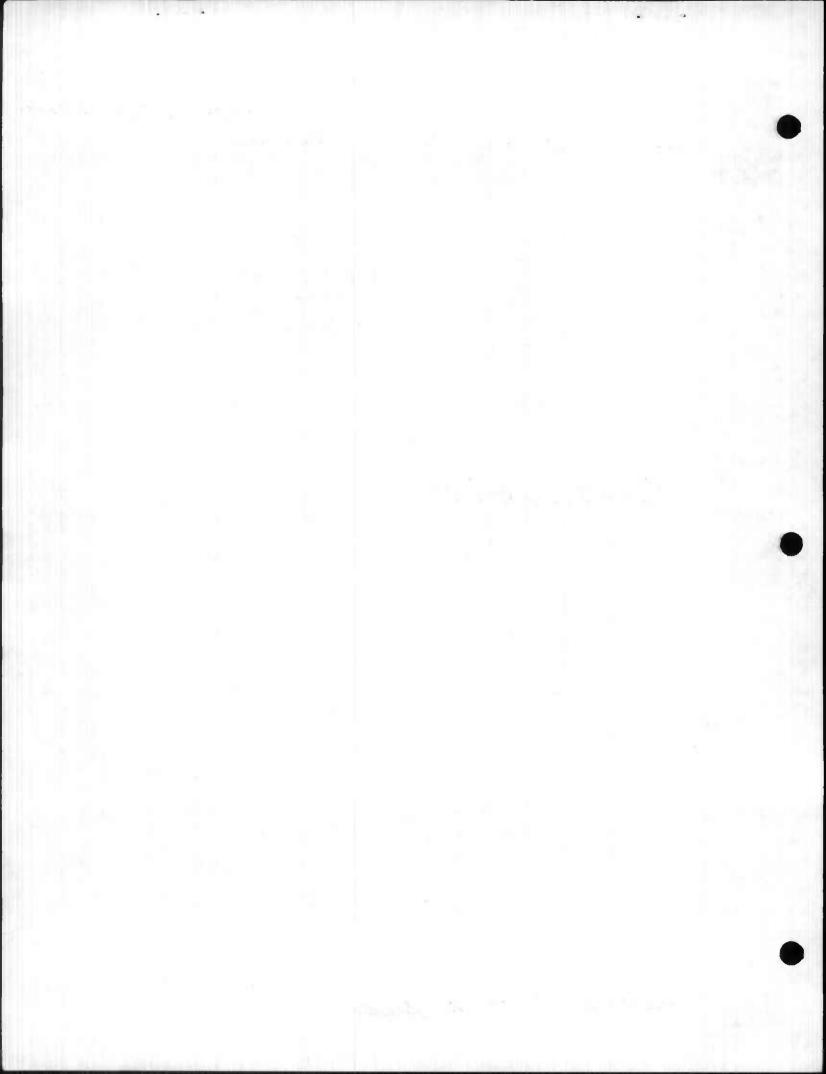


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Lest) 2. Data of Death 3. Time of Death Day **Physician** August 29 1999 cation of Death 4c. County of Death Channie L. Morton 12:05 Pm /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Care Center Kholl Baltimore Lruington N/A If Under 1 Yaar If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthpleca (Stete or Foreign Country) Months Days Min. 1 ☐ M 2 ☐ XF Hours 74 Yrs. 127-22-8262 Director Jun 12, 1925 VA Usual Residence of Decedant Pages 1 end 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or items 23s or 28s-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f ehor traumstic avent, the Medical Examiner must be notified at Director 1 Yas 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 West Baltimore St. Apt.308 21223 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Giva Yeer or Dates: 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Dacedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) Hospital Elemantary/Secondary (0-12) College (1-4or 5+) Nurse's Assistant Maryland 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Willie Morton Arelia Walker 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If Itam 27 Is any Injury or other tra-once. Miss Ida Mae Morton (Daughter) 1518 May Court, Baltimore, MD 21231 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State Sep 3 4 ☐ Donation 5 ☐ Othar (Specify) Voshell Memorial 1999 Baltimore, MD 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 1 2818 East Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Cerebro va saulo month Examiner Due to (or es a consequence of) 2 Tus Examiner dysphagia To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician encompletely filled in by the funeral director, page 2 should be deteched for use as the bursh-transit Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that Initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760, Physician/Medicai Dua to (or as a consequance of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Division of Vital Records, by Completed 24a. Was en eutopsy 24b. Were eutopsy findings available prior to complation of cause of death? performed' 1 Yes 2 PiNo 1 Tyas 2FTNo Be 25. Was cese raferred to medicel examiner? 26. Place of Daath (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the bast of my knowledga, daath occurred at the time, date end place, end due to the causa(s) end manner es steted.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29a. Certifiar Medicai (Check only one) 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Dey, Year) mien - Door Krong, mo D31865 30. Name end addrass of parson who complated causa of daath (Item 23a) (Type, Print) N Gutan street Baltimore And 2/20/ Rm 206 Kroung 821 Wien-0 32 Registrar's Slocature State Registrar



3. Time of Leath

2. Data of Death

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1. Decedent's Nama (First, Middla, Last)

Mag1iano Victoria

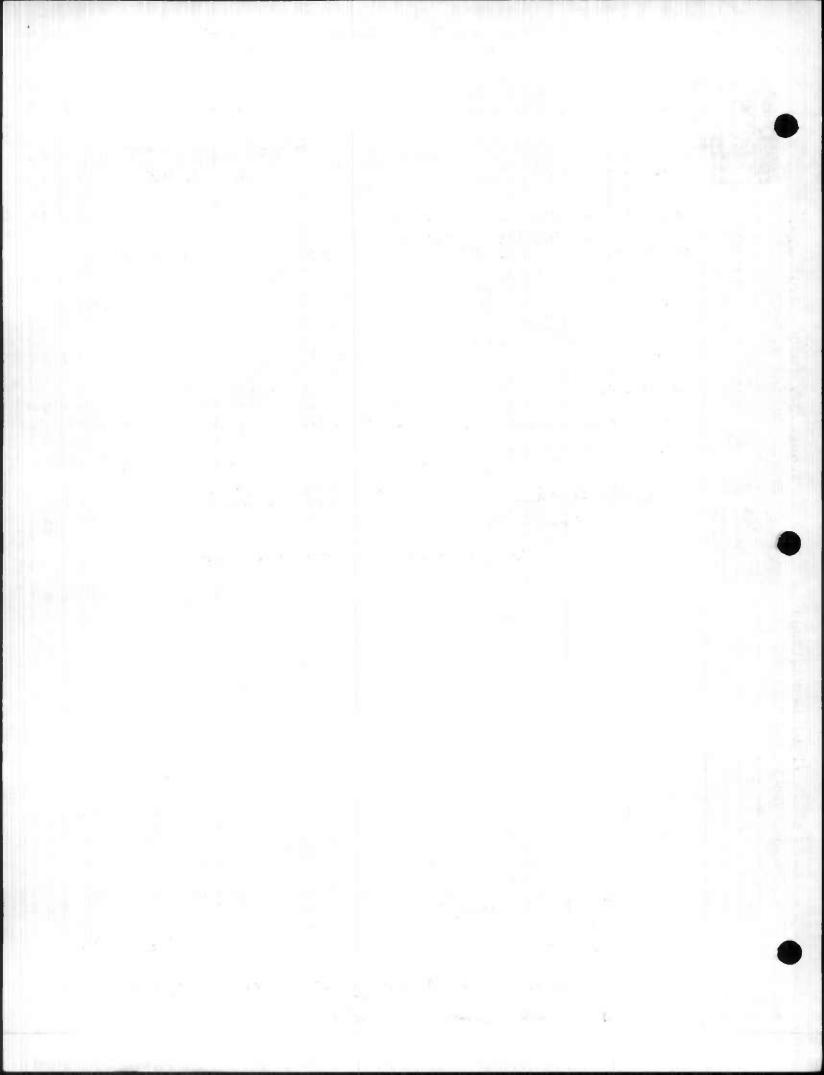
Physician 27, Victoria Magliano August 1999 7:05 A.M. /Medicai 4a. Facility Nama (If not Institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) if Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foraign Country) 1 M 2 K Months Days 213-01-1382 Yrs Director Oct. 17, 1901 Italy Usual Rasidance of Decadant 10e. Stata 10b. County 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 10d. inside City Limits Maryland Baltimore Director Timonium 1 Yes 2 No 100. Street and Number St. Elizabeth Apartments 10f. Zip Coda 10g. Citizen of What Country? 2300 Dulaney Valley Road HC 104 21093 United States 11. Maritai Status 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 🛣 No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify by 3. Widowed 4 □ Divorced White Completed 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collage (1-4or 5+) Seamstress Sewing Factory 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Be Philip Trotta Archangel Trotta 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 1104 19a. Informent's Neme/Ralationship (Type, Print) Department of Health important: if item 27 is any injury or other tra Health 2300 Dulaney Valley Road Timonium, Md. 21093 Mr. A. Donald Magliano (Son) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Bunal 2 Cramation 3 Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Spacify) Oak Lawn 8/30/99 Baltimore, Maryland 21. Signatura of Funarai Sarvice Licensas 22. Nama and Addrass of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disclass accomplications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failuse list in the mode of dying, such as cerdiac or respiratory errest, **Physician** /Medical immediata Causa (Final disaasa or condition resulting in deeth) Chronic Obstructive Pulmonary Disease Examiner Dua to (or es a consequence of): Examiner the death certificate be executed burial-transi Sequantially list conditions, if any, leeding to immediata ceusa. Enter Undarlying Causa (Disaase or injury that initieted avants rasulting in daath) Last Dua to (or as e consequence of): physician s the buria Physician/Medicai Dua to (or as a consequence of) 88 Part ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown should be d þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes cesa raferred to medical axaminar? 26. Pieca of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Mother (Specify) Hospice 1 Yas 2 No Medical Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 27. Mennar of Death 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred After 1 XNaturel 5 Pending invastigation s after death.

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In by the fu 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be determined Plece of injury - At home, ferm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homloida within 24 hours a To the Funeral D Hospital 29a. Certifian 1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. completely ş 29b. Signatura and title of sortifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D43725 30. Nema and eddress of person who completed ceuse of deeth (Itam 23a) (Type, Print) Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatur

State Registrar

AUG 3 1 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Marion Isabelle Mitchell 26, 1999 August 11:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2113 Round Hill Road Fallston Harkord If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2/□F 74 Yrs. Dec. 4, 230-22-5687 1924 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Maryland Harkord Fallston Director herna 23a or 28a-f 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 2113 Round Hill Road 21047 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried natural, or altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 Pages 1 and 2 should be nent of Health and Mental Important: If Nem 27 is marked , any injury or other traumatic ev. 2009. James Robert Scott, Sr. Ethel Mae Keeler 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Anne Fiesel (daughter) 2113 Round Hill Road, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burlel 2 □ Cremetion 3 □ Removal from State Parkwood Cemetery 8/30/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** RETTST CANCER /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 412 Unknow be det Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 TYes 2 No Division of Vital Hospital or Attending Physician: '24 hours after death.'
 Funeral Director: After this certifical eleby filled in by the funeral director, p. 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) To the I 29b. Signetare end title of Certifies 29d. Date signed (Month, Day, Year) 31775 MARZIAN BELAIR and address of person who completed cause of death (Item 23a) (Type, Print) P. EDWARDS M. 1)

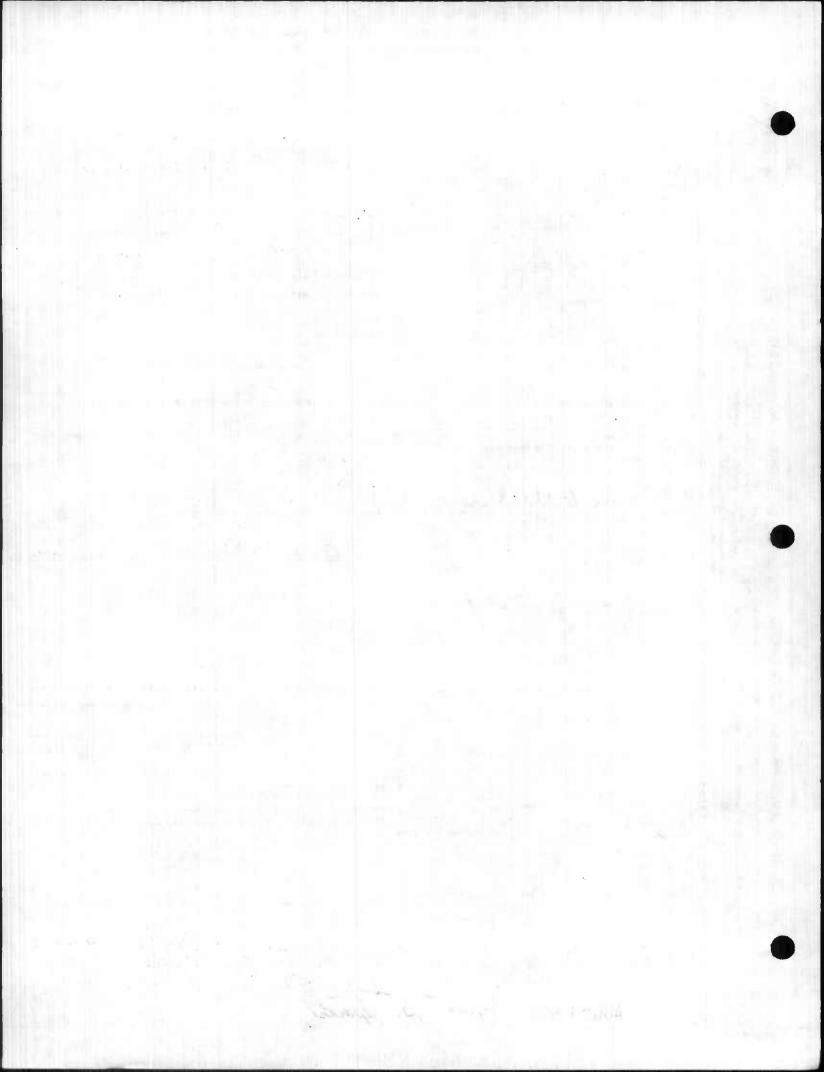
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG31



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 140081 28 1999 MORRISON 4b. City, Town, or Location of Death 4c. County of Death Baltimore City

death with the Maryland r than "natural", or itema 23s or 28s-f ahow the Medical Examiner must be notified at

1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** LUMHOL 1230 PM /Medical 4a Facility Neme (If not institution, give street and number) Examiner Sinai Hospital If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 08-12-1932 Birthplace (State or Foreign Country) Funeral Days Months Hours North Carolina 125M 2□ F 246 44 4109 67 Director Usual Residence of Decedent 10a. Slete 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland N/A Baltimore City 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4007 Emmart Avenue 21215 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, pormit, Pages 1 and 2 should be filed within 72 hours after c. Department of hearth and Mental Hygiene.
Important: If them 37 is marked other than "natural", or frem any injury or other treumatic event, the Mental. Bleck, Whita, etc. 1 Never Merried 2 Married Specify: Black 1 Yes 2 No Specify: by 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baker Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 unknown unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charlotte Brown/Neice 4007 Emmart Avenue, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1

Burial 2 □ Cremetion 3 □ Removel from Stete

□ Donetion 5 □ Other (Specify) King Memorial Park 9/4/99 Woodlawn, Maryland 22. Name and Address of Facility
William C. Brown Community Funeral Home 21. Signature of Foreral S 1206 W. North Avenue, Baltimore, Maryland 21217 relling 23a. Part 1 Prite the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 attending USB ó ed by the 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. been signed by should be detact No 3 Probably 4 Unknown 1 Yes P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

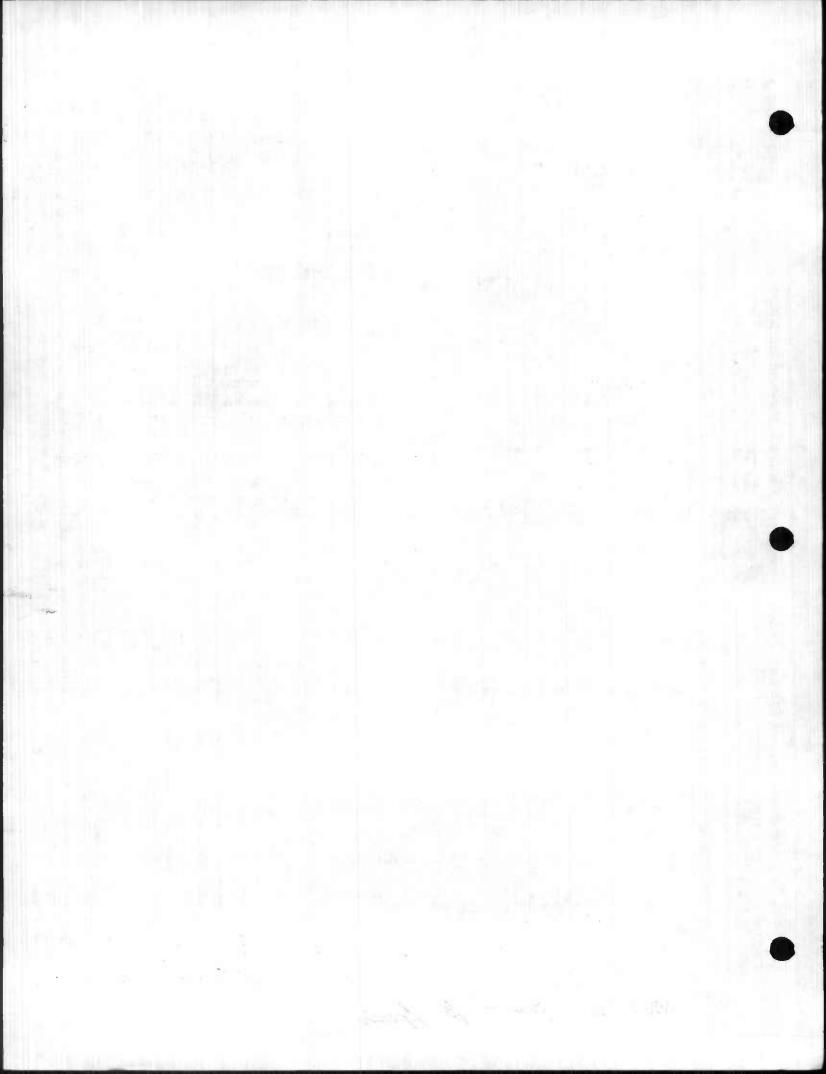
12 Yes 2 No å 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Manner of Death 26a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After Attending 1 Natural 5 Pending investigation ne Hospital or Attending 124 hours after death. The Funeral Director: After 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my spiritual texts. 29a. Certifier edical ical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and/manner steted. (Check only one) To the To the F 29b. Signeture and who completed calling of death (Item 23a) (Type, Print) AVE BATIMONE 740

State Registrar

DHMH 16 Rev 6/95

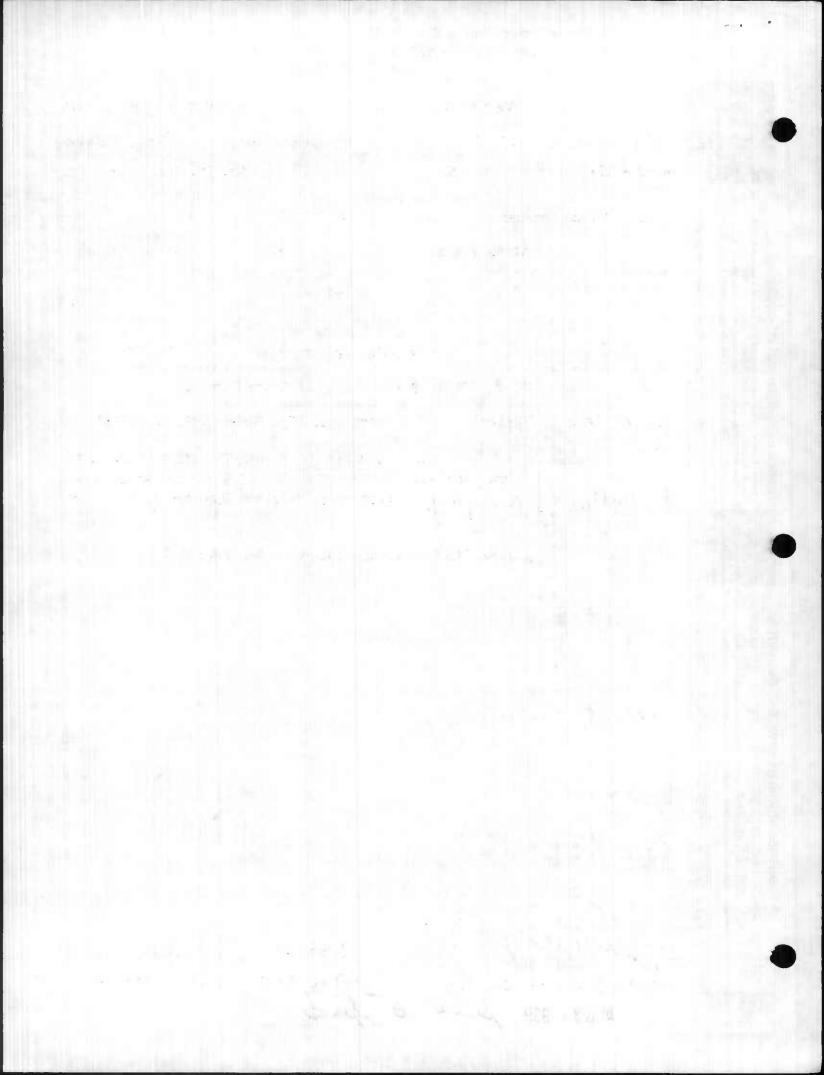
32. Registrar's Signature



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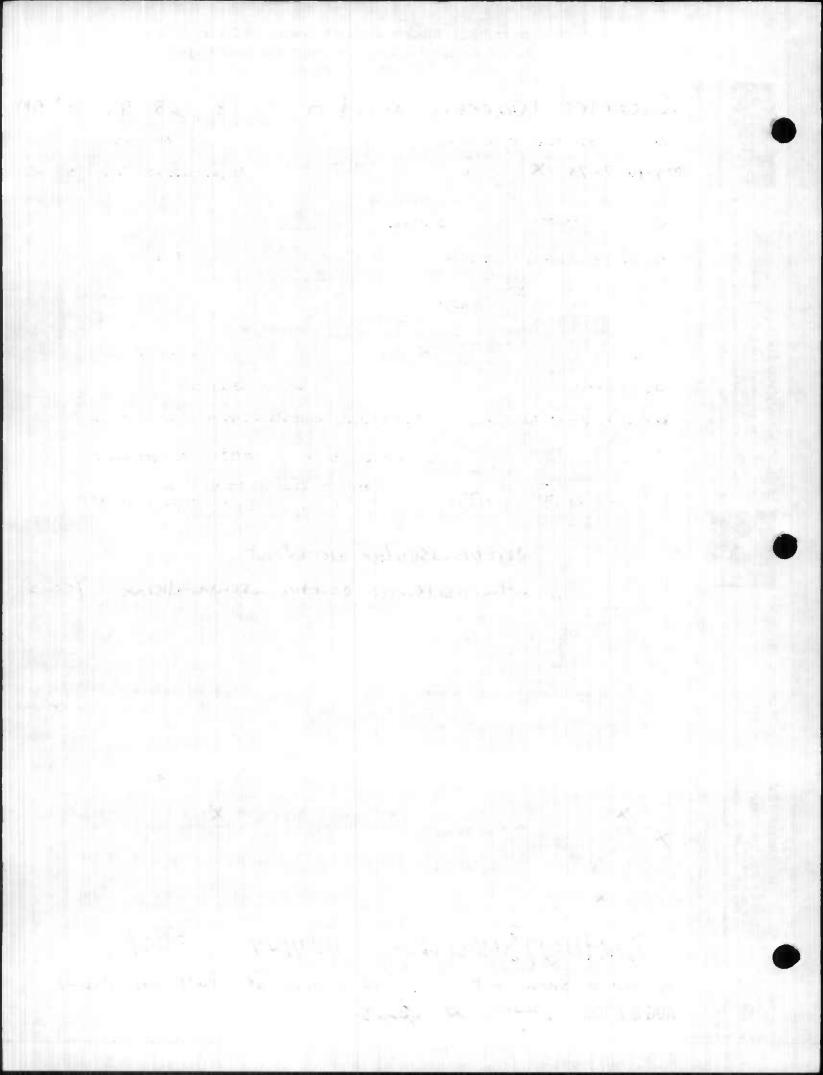
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-			2 P PLATEAU 5. Social Security Number 6.5		e (In yrs. le:	st hirthdayl	If Under 1	GREE		Date of Birth			ORGES					
	Funeral Director			⊠ M 2□ F	62	Yrs.	Months [Deys Hours	Min.	Date of Birth (Month, Dey lay 29,	1937	New Count	lece (State or Foreign try) Jersey					
	and tand		10a. Stete 10b. County		10c. City,	Town or Lo	cation					10	Dd. fnslde City Limits					
h the Maryland r 28a-f show chordfled at	to	Md. Prince G	eorges			G	reenbelt					1 ☐ Yes 2 💢 No						
	3a or 28a	Funeral Director	10e. Street and Number 2 P	Plateau P	lace		10f. Zip Co	207	70	1	Og. Citizen of United		*					
020 burs after death with It rel', or items 23s or 2	Jr.	P	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Yeer or Detes:	4000	-		t of Hispenic Orig Cuben, Mexicen, (No Specify:	In? (Specif Puerto Ric	fy Yes or No- can, etc.)		ce - America ck, White, o						
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducetion ade completed)		16e. Dece	dent's Usual C	occupation fone during most	16b. Kind of B	lusiness/ind	lustry							
2121 d within giene.	Men.	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	16e. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Computer Programer			11 0		II S GO	. Goverment						
	lled v tygie ther ti	ပိ	17. Father's Name (First, Middle, Last,			Comp	uter Pi		's Name (I		Meiden Sumei							
an	S E D	m	TT. I MITOL STAINS (FINAL FINAL Angelo Ma	rconi	Sr.				Ferran		no,							
more, Mar		2	19a. informant's Name/Reletionship (ng Address (S	treet and Number				, Stete, Zip	Code)					
	2 8 2 8	4	Jeanette Love	(Sister)			Grant A			bor TW		08234						
	ant of t: If it y or o	3	20a. Method of Disposition 1 🕱 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specif	Removel from State		ce of Disponetery, crem	osition (Name metory or othe Cemete	of r pleca)	7	Date	20c. Location							
Baltii	Dealtimo		21. Signature of Funeral Service Licer			Jr 22	2. Name and /	ddress of Facility	53	05 Har	ford Ro	oad .	21214					
_	20100	4	23a. Part1. Enter the disease, or comshock, or heart failure. List only.	- Kny	eny			re, Mary				Ruck,	Inc Approximate					
E	/Medical Examiner	al Examiner	miner	miner	miner	niner	Immediate Ceuse (Finel disease or condition resulting in deeth) e. ARTERIOSCUEROTIC CARDIOVASCULAR PISEASE Due to (or as a consequence of): b.											
60,	ifficete be executed g physician and as the bunel-transit		Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events	с	Due to (or a	e to (or as e consequence of):												
x 68760,	5 04	resulting in death) Last d.									> ,							
Вох	ires that the death cer signed by the attendin d be deteched for use	Clar	Dort II. Other elanificant conditions of	antibution to death b	uting to death but not resulting in the underlying ceuse given in Part i.					22h Dide	23b. Did tobacco use contributa to the cause of death?							
o.	the or the echec	nys			ut not result	ing in the u	noerlying ceu	se given in Part i.			o 2□ No	3 □ Prot						
S, D	E 90	D P	DIABETES ME	LUITUS							20110							
Record	law requires as been sign s 2 should be	Completed	24a. Was an auto performed?								eva cor	ore autopsy findings alleble prior to appletion of ceuse death?						
	The law ate has page 2	E								1 □ Y	es 2 No	10	Yes 2□ No					
Viital	certificate rector, pag		25. Wes case referred to medical					26. Plece	of Death (Check only o	ne)							
>	5 00	0	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2 E	R/Outpatier	nt 3 DOA	Other: 4 Nur	sing Home	5 Resid	ence 6 □Ot	her (Specify	1)					
ion of	Attending Ph ir death. actor: After th by the funeral		27. Menner of Deeth 1 Naturei 5 Pending 2 Accident investigation	Injury et Work?		d. Describe h	ow injury occu	rred										
Division	al or Attending is after death. I Director: After din by the fune.	27. Menner of Deeth 1 Naturei 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occ 28d. Describe how injury 28d. Describe how injur										ber or Rural Route Number,						
	n 24 hound Peter Pletely fill	edical		yelclan: To the best on niner: On the basis of and manner str	examination													
	To the composition of the compos	Ž	29b. Signature end title of certifier	tona			29c. L	icense number		3	29d. Date sign	ed (Month,	Dey, Year)					
			30. Name and address of person who	completed cause of d	eath (Item 3	(1 23a) (Tyne	Print)	1339159			August	30	1999					
			MARIO F. GOLL 31. Dete filed (Month, Dey, Year)	FJR	MO ar's Signetu	300	1-00	THE PEN	VE,	CHEVE	er, m,	SPYLA	ND 20785					
	State Registra	5	and the second s	399	was	B.	do	uls										

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Deeth 28 **Physician** Marti harles Warren /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 E. Joppa Road, Unit 1904 Towson Baltimore 8. Date of Birth (Month, Dey, Year) Aug. 13, 1 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 XM 2 F Months Days Hours Min 577-10-7878 Yrs. 1920 79 Director Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "natural", or itams 23a or 28a-f ahow traumetic event, the Modical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with permit. Pages 1 end 2 should be filed within 72 hours after death a Deportment of Health end Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner mant once. USA 205 E. Joppa Road, Unit 1904 21286 Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. n XYes 2 □ No If Yes, Give Year or Dates: WWII 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: þ 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Industry Elementery/Secondery (0-12) College (1-4or 5+) Newspaper 12 Manager 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father'a Neme (First, Middle, Last) Albert Martin Harriet Barlwick 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 786 Valentine Road, Crownsville, MD 21032 Tracey A. Nosal (Daughter) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 08/31 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signeture of Funeral Service Licenses rulla 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heart teilure. List only one cause on each line. Approximete tnterval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel cerebrovascular diseese or condition resulting in death) Examiner Examiner cerebrovascular diseve atheroscierotic ettending physician and for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of): detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? Completed peen certificate has 1 Yes 2 No 1 Yes 2 No Attending Physician: funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After Naturel Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde 29a. Certifier (Secrifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. completely (Check only one) 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed, (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Greene St MP Dorothy AUG 3 1 1999 32. Registrer'a Signeture Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Doris N. Myers August 26, 1999 7:21 AM 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rossville Baltimore 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1 ■ M 2 🖫 F 219-10-2034 72 11-28-1926 Maryland Usual Residence of Decadent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏋 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorcad 18a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Reidy Violet Wasmuss 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Barbara A. Phoebus (Daughter) Cottington Road, Baltimore, Maryland 21236
e of Date 20c. Location - City or Town, State 4320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 ☐ Burie! 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 DOther (Specify) Entombment Dulaney Valley Maus Timonium, Maryland 8-28-99 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S. Brook, Ir 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiralory arrest, Approximate Intervel Between Onset and Death PULMONARY EMBOLISM Immediate Ceuse (Final 20 minutes disease or condition resulting In death) Due to (or as a consequenca of): Immune Suppression 6 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): transplantele Renal 6 weeks Due to (or as e consequence of): failure Renal Chronic Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown LEAKAGE BILLARY 24b. Were eutopsy findlngs available prior fo completion of ceuse of death? LHOLECYSTECTOMY 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Alatural 1 ☐ Yes 2 ☐ No

attending physician and for use as the burial-transit death certificate be executed Box 68760, signed I Records, page 2 s certificate hes Division of Vital Attending Physician: director. After this the funeral 24 hours efter death. Š To the Hospital

Certification:

Physician

/Medical

Examiner

Funeral

Director

28s-f show

23a or

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natural, or

Hygiene.

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permit. Pages 1 and 2: Department of Health as Important: If Itam 27 is any Injury or other tracence.

Physiclan /Medical

Examiner

Health and Mental

the Medical Examiner must be notified at

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Funeral

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Completed

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the Maryland

altimore, Maryland 21215-0020

þ Completed Be

Physician/Medical Examiner 2

Medicai

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death

(Check only one)

29b. Signeture and title of certifier

2 Accident 6 Could not be determined 3 ☐ Sulcide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 030182

29d. Date signed (Month, Day, Year) AUGUST 27, 1589

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

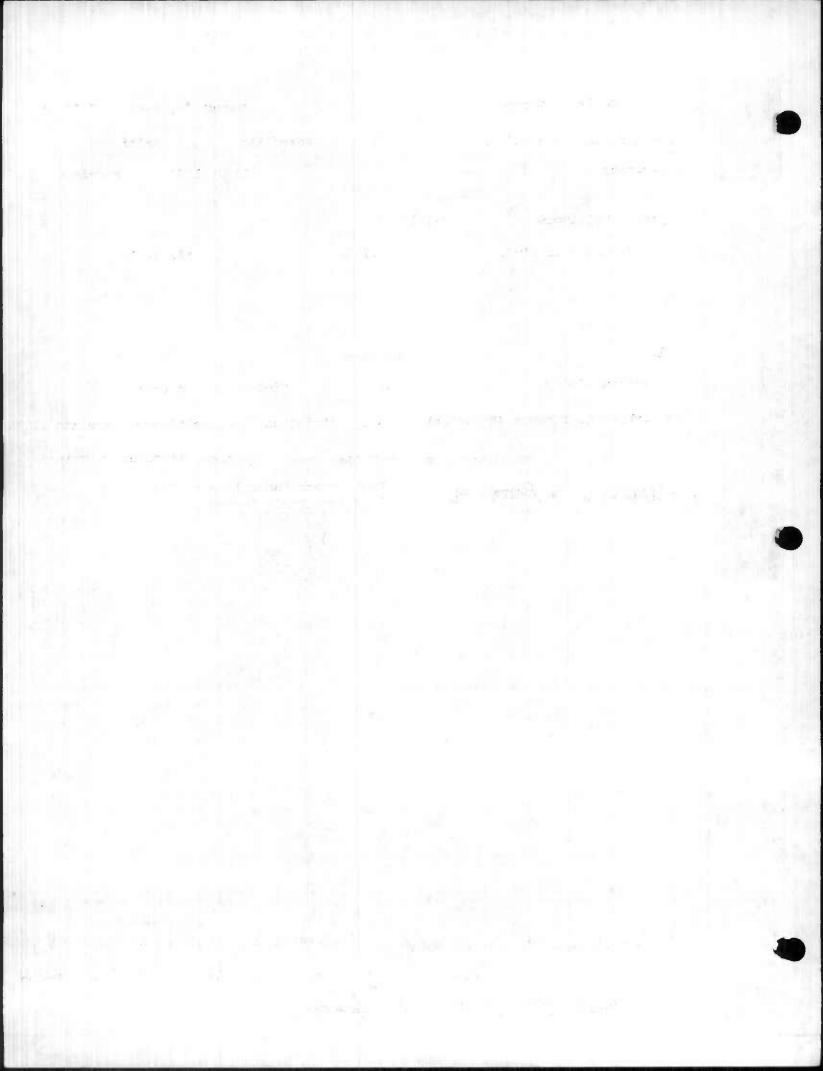
JUSSELL MD 8800 Walter Blyt Baltimore MD21234

32. Registrer's Signature

this m Rusself

State Registrar

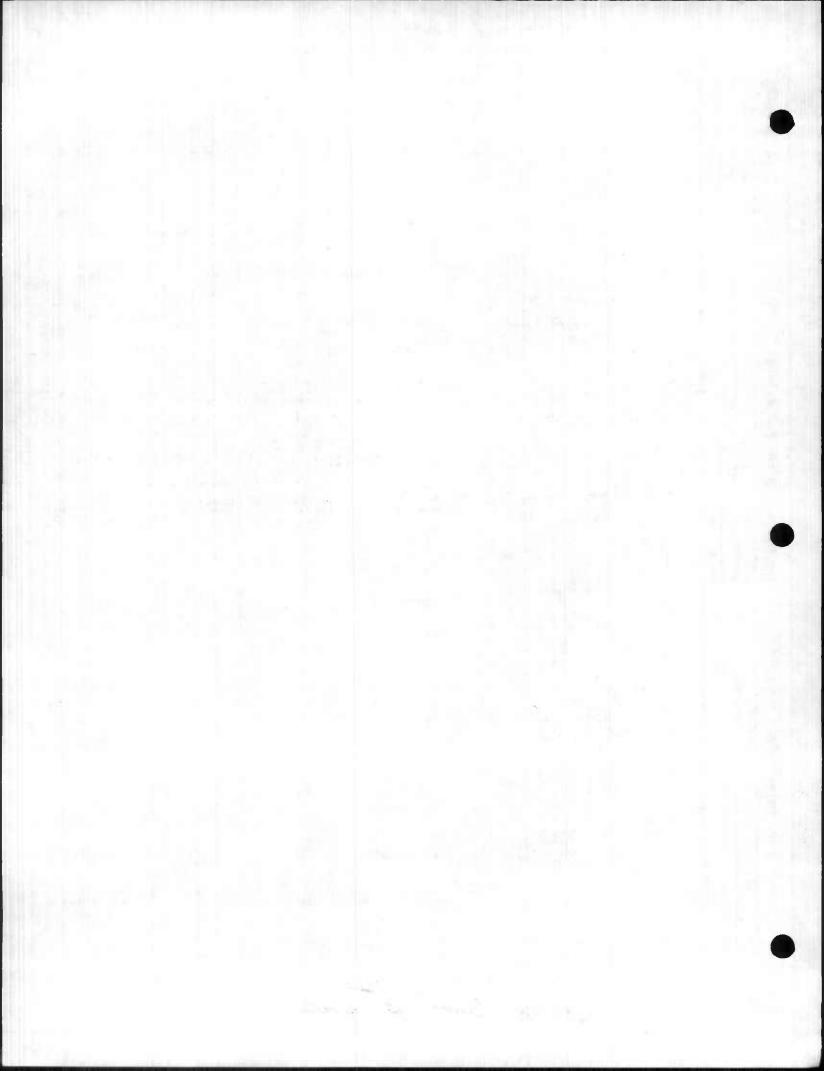
within 24 hor To the Fune completely fi



Division of Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0020
or Attending Physician: The law requires that the death certificate be executed XX William (1991).	Described to Health and 2 should be filed within 72 hours after death with the Maryla
Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	o o important; if then 17 is marked other than "natural", or heme 23s or 28s-f sho o arry injury or other traumatic event, the Medical Examiner must be notified at
rification: To Re Completed by Dhysician Madical Evamine	

						ertificate		Death		Reg. No.	2 6	1000			
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17.1	dical	ANITA L.		LLER					Augu		1999	9:45 am			
Exan	niner	4e Facility Neme (If not institution,	give street and number)					4b. City, Town, or	Location of Deal	h 4c. Coun	ty of Death				
		Stella Maris						Timonium		Balt	imore				
Funer	al	5. Social Security Number			(In yrs. last birthday) If Under 1 Ye Months Da		1 Yeer Days			rth av. Year)	9. Births	Birthplace (State or Foreign Country)			
Directo	or	215-01-8579 97 Trs. A								, 1902	1	Md.			
5 .		Usuel Residence of Decedent 10a, Steta 10b, County		100 010	. Town or	Location									
aryta det		10a. Steta 10b. County		10c. CR	y, Town or	Location					1	10d. Inside City Limits			
the Maryland 28a-f show solified at	Director	Md, Baltimore Timonium										1 ☐ Yes 2 ☑ No			
0020 ours after death with the Maryla raf, or items 23s or 28s-f shor Examiner must be notified at	ě	10e, Street and Number				10f. Zip (Code			10g. Citizen of	What Cour	ntry?			
10 W	100	2300 Dulaney Valley Rd. 21093 USA													
de de	Funeral	11. Maritel Status	12. Wes Decedent Armed Forces?	Ever in U,	S. 1:	3. Wes Decede	ent of h	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No	o- 14. Ra	eck, White,				
0 4 29		1 Never Merried 2 Merrie				1 ☐ Yes 2			(),,			oto.			
Iryland 21215-C thould be liled within 72 h of Montal Hygiere. marked other than "nettu metic event, the Medical	by	3 ₩ Widowed 4 Divorced	Year or Detes:				140	Spaciny.		Spec	wy. Whit	0			
	Completed	15. Decedent's (Specify only highest	Education	16a. Decedent's U			nt's Usuel Occupation and of work done during most of working NOT use retired)			16b. Kind of	Business/In	dustry			
	혍	Elementery/Secondary (0-12)	College (1-4or	5+)			e retire	d)	9						
	ő	12	11/2/02/31		Cler	·k					ore C	ity			
	Be	17. Fether's Neme (First, Middle, Li	ist)					18. Mother's Ner	me (First, Middle	rst, Middle, Maiden Surnei					
	0	William	F.	Hel	1manr	1		Bridget		C.	N	orris			
	- 5	19a. Informent's Neme/Reletionshi	(Type, Print)		19b. Me	iling Address	(Street	end Number or Ru	ural Route Numb	er, City or Tow	n, State, Zip	Code)			
and 2:		Mr. James Prenge	er/guardian		2030	Pot S	pri	ng Rd. Lu	ithervil	le, Md.	2109	3			
ultimore oit. Pages 1.1 artment of He artant: If Nem injury or oth		20a. Method of Disposition		20b. P	lece of Dis	position (Nem	e of her ple	ce)	Dete	20c. Location	- City or To	own, Stete			
		1 Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spe				d Cemet			8/31/99	Parky	ille.	lle, MD.			
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B SOFE	8	The late	1000	1	son Fune										
		23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.													
Physicia	,	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximation of the control													
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Examiner	er	disease or condition resulting in deeth) ARTERIOSCLEROSIS Due to (or as a consequenca of):													
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58 / 50, icate be executed physician and s the burial-transit	EXB	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.													
icate be ex physician s the burial	6	Ceuse (Diseese or injury thet initieted events	C	D							t				
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ecords, P.O. Box to law requires that the death certific as been signed by the attending p 2 should be detached for use as:	N.		d												
Both cert attending for use	Physician/M														
uires that the decree is signed by the alid be detached to	ys	Pert II. Other significant condition	contributing to death b	ut not resu	ulting in the	underlying ca	use gi	ven in Pert I.				o the cause of death?			
T ta be		KENS	131/212						10	Yaa 2 No	3 Pro	bably AB Unknown			
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v require	Completed	1182688	3/10	365)						ormed?	av	ailable prior to impletion of cause			
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E 60 60									10	Yes ZUNo	1.0	☐ Yes 2☐ No			
ysician: Tha lis certificate he director, page	e e	25. Was case referred to medical examiner?	44				100	26. Piace of Dec							
OIVISION OF VITAL or Attending Physician: 7 siter death. Director: After this certificat i in by the funeral director, p.	2	1 ☐ Yes ZŒNo	Hospitet: 1 Inpatio		ER/Outpat			her: 4 Nursing H				(y)			
ng P her t	ü	27. Menner of Death 1. Neturel 5 □ Pending	28a. Dete of Inju (Month, Da	y Year)	28b. Time Injury		kc. Inju Wo		28d. Describe	how injury occi	bernu				
Sath.	at	2 ☐ Accident investige	the:			М	1 🗆	Yes 2 □ No							
Py de de	₹	3 Suicide 6 Could no 4 Homicide determin		ury - At ho	me, farm,	street, fectory,	office			(Street end Nun wn, State)	nber or Run	al Route Number,			
2 2 2 2 C	Certification:														
hou hou	Caj		Physician: To the best												
UIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai	one)	aminer: On the basis of and manner st	eted.	TOTA MITOUR	miresugenori, i	ar my (Amilion, deem occu	च्य वर ग्राप्त गारित	vale one piace	, and due to	0 (110 Caldod(s)			
To the total	2	29b. Signature and title of certifier.	//	no		29c.	Licens	se number	1	29d. Date sign					
		1 / Vaca	led's					D 1550	4	8. 5	7.49				
		30. Neme and address of person wi													
		Eddie Nakhu	da, M.D.	230	00 Du	ılaney	V	alley Ro	d Ti	monium	Md .	21093			
S	tate	31. Date filed (Month, Dey, Year)	32. Registy			-	1	_							
Regis		AUG 3:	L 1999	iner	/	0. 4	000	K							
DHMH 16 Ray 6	5/95		- 1												

MILLER, ANITA



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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAD'S SIGNATUM

Zubair M. Syed, M.D.

AUG 3 1 1999

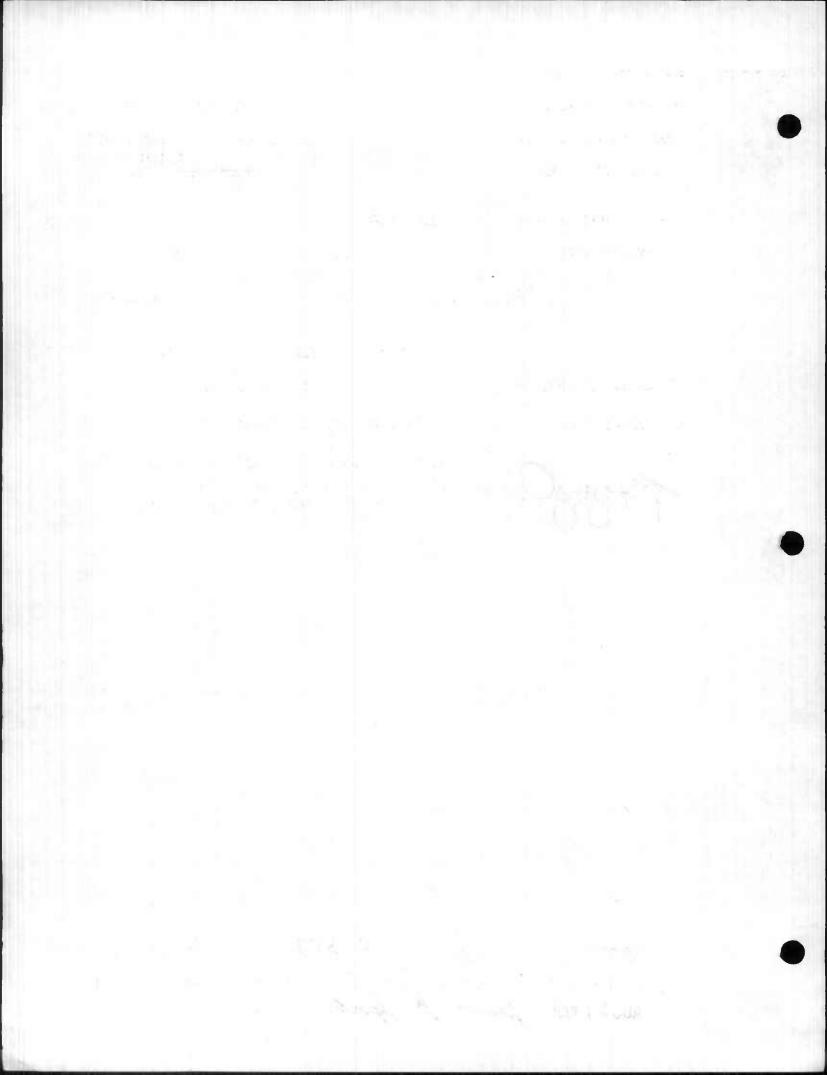
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 19, 1999 Aügüst Urcel Owen McCusker 7:10 a. M 7. DATE OF BIRTH (Month, Day, Year)
December 7, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER I YEAR IF UNDER 24 HRS. HOURS 1 X M 2 - F 220-30-7539 YRS. 65 Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Colton Villa Nursing Center Washington Hagerstown 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Washington Hancock 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13223 Exline Road 21750 USA 11. MARITAL STATUS t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Sporting/Hunt Club 10 Caretaker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Austin William McCusker Anna Mae Miller 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gail V. McCusker/Brother 13002 Woodmont Road Hancock, MD 21750 20s. METHOD OF DISPOSITION

TO Burlel 2 Cremation 3 Removal from State
4 Donation 5 Octoor 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Mt.Olivet Presbyterian Donation 5 - Other (Specify) 8/21/99 Hancock, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 23. PART i. Enter the diseases, or compileations the cliused the des shock, or heert fellure. List only one cause on each line. mused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, **Approximata** interval Between **Onset and Death** IMMEDIATE CAUSE (Finel disease or condition Congestive Heart Failure resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): Hypertension CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Coronary Artery Disease CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated aventa resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAIL ABLE PRIOR TO Diebus Mulita COMPLETION OF CAUSE OF DEATH? 1 YES 2X NO Epider 1 Asses-1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES KI NO UNCERTAIN U PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2X NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(a) and menner as stated. 296. SIGNATURE AND THE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ans D52055 8/26/99

130 W. High St, Hancock, MD 21750

MENDED ITE	M #	8 PER FH G775 9/1/99 AH		laryland / Dep Co	ertificate of		nd Mental H	Reg. No.	9 2	7340	
Physic /Med		1. Decedent's Name (First, Middle, Last HOWARD J. PIERSO	N, JR.				2. Date of Month AUGU	ST 28, 1	9 9 9 °	3. Time of Death 12:45 PM	
Exam	ner	4a. Fecliity Name (If not irrstitution, give NORTH ARUNDEL HO)		GLEN 1	n, or Location of De		ANNE ERUNDEL		
Funera Director		5. Social Security Number 218.26.0193 Usuel Residence of Decedent	x 7. A	ge (In yrs. last birthda 67 Yrs.	Months Days	If Under 2	Min. 8. Dete of 1	Birth 10/1/31 9. Birth 20/1/31 9. Birth 20/1/31 MD		rthplece (State or Foreign ountry)	
Offer death with the Maryland offer death with the Maryland or terms 23s or 28s-f show or terms to a notified at	ector	10a. State 10b. County MD ANNE ARU 10e. Street and Number	NDEL	10c. City. Town or GLEN B				100 Chinas of		od. Inside City Limits	
ath with	Funeral Director	9 BAYLOR AVENUE				10g. Citizen of	SA				
15-002 n 72 hours "natural", e	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 12. Yes 2 I If Yes, Give Year or Dates:	KOREA	. Was Decedent of H If Yes, specify Cubin	Specify:	in? (Specify Yes or I Puarto Rican, etc.)		ca - America ck, White, e y: WHIT	tc.	
	Completed	15. Decedent's Edu (Specify only highest grad Elemantary/Secondary (0-12)	e completed)	on mpleted) 16a. Decedant's Usual C (Give kind of work life. DO NOT use) PHOTO COM			of working	16b. Kind of Business/Industry MONOTYPE COMPOSITION			
2 should be filed within and Mental Hygiene. Is merked other than aumetic event, the Memetic event even	To Be	17. Father's Name (First, Middle, Last) HOWARD J. PIERSON	, SR.				IAN FOUSE		ne)		
m 2 m 2		19a. Informant's Name/Relationship (T) MARGUERITE PIERSO 20a. Mathod of Disposition 1 X Nurial 2 □ Cramation 3 □ F	N - WIFE	9 BA	LOR ROAD, position (Name of ematory or other plan	GLEN					
permit. Pages 1 ar Depertment of Hea Important: if item; any injury or other once.		4 □ Donation 5 □ Other (Specify) 21. Signature of uniaral Service Licer KELLY GREGORY	- Dil 6	GARDEN	S OF FAITH 22. Name and Addra FINK FUN	ss of Facility		9 BALTIMO			
Description of the provided by	/Medical Examiner	23a. Parl1. Enter the disease, or combi- shock, or heart fature. Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Pue to (or as a conse	IBRILLATIO equenca of):					Interval Between Onset end Death	
the school	Physician/Me	Part II. Other significant conditions con	tributing to death t	out not rasulting in the	underlying cause giv	an in Part I.		d tobacco use co ☐ Yes 2 ☐ No		the cause of death	
T VICAL RECORDS, yslcien: The law requires is certificate has been sign director, page 2 should be	24a. W. pe								com of d	a autopsy findings lable prior to spletion of cause eath?	
	To Be	25. Was case referred to medical examiner? 1 Yes XXNo F 27. Manner of Death XXNatural 5 Pending investigation	lospital: XX Inpati 28a. Data of Inju (Month, Da	ry 28b. Time	of 28c. Injur Wor	ar: 4□ Nurs	of Death (Check only sing Home 5 - Re 28d. Describ				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	I Certification:	3 Suicide 4 Homlcida 6 Could not be determined		ury - At home, farm, s c. (Spacify)			City or 7	f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hos within 24 ho To the Fun completely	Medical		er: On the best and manner st	of my knowledge, dea f examination and/or l ated.	pinlon, death	piace, and due to the occurred at the time	a, date and place,	and due to	tha causa(s)		
5 Miles		1 Again	moleted cause of	leath (Item 23a) (Type	D43	29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) Agent 26, 1494				1499	
Sta Regist		Out the Oblings 31. Date filed (Month, Day, Year) AUG 3 1 1999	32/Registr	ar's Signeture 9.	South	n Bn	ml.	moi	2406		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Data of Death au gust 99 MELVIN JOHN PTERSON

3. Time of Death

	Physic /Medi Examii	cal	
	Funeral Director		
d 21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or frems 23s or 28e-f show int, tra Med cal Examinat must be notified at	Completed by Funeral Director	

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked othe any injury or other traumatic avent, page.

Baltimore, Marylan

Physician /Medical Examiner

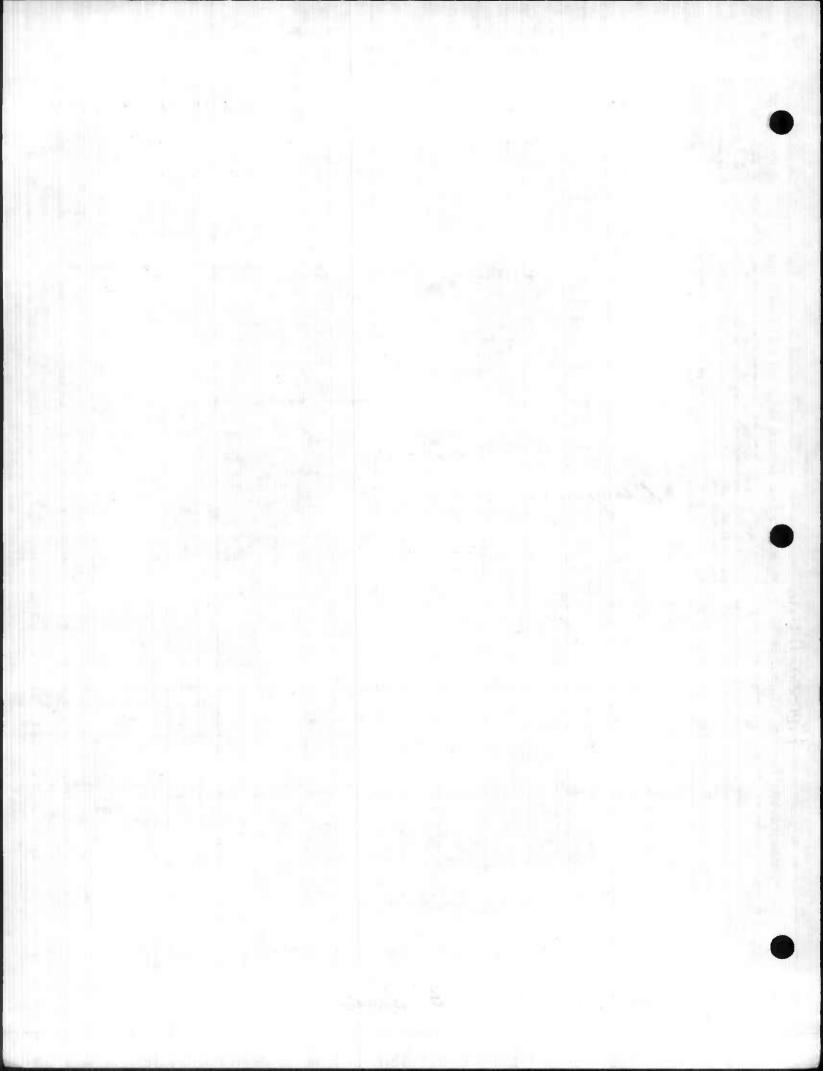
Pierson, Melvin the burial-transit and Division of Vital Records, P.O. Box 68760, ed by the a been signed by should be detac page 2 certificate this

or Attending Physician: funeral After deeth. n 24 hours after deeth Ne Funeral Director: A pletely filled in by the f Hospital completely To the P 0

4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death FALLSTON GENERAL HOSPITAL HARFORD COUNTY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Months 10XM 2□ F 84 Yrs. 218-07-0180 April 09 1915 Maryland Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1435 Battery Ave. 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ft Yes, specify Cuben, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 1 Navar Married 2 Married ☐ Yas 2 ☐ No I Yas, Give 1 ☐ Yas 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad unknown unknown Brakeman 17. Fathar's Name (First, Middle, Last) 18. Mother'a Nama (First, Middle, Maiden Sumama) å Sophia Fangmann unknown 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5 Beech Leaf Court, Baltimore, Md. 21286 Margaret R. Cronyn (Friend) 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 8/28/99 Baltimore, Md. 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 2 Long 21230 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Sequentially list conditions, if any, laading to immadiate cause. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably by Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? Be 25. Was casa ratarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Impatient Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 20 No Medicai Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Panding invastigation Vatural 1 TYas 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifian (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifia ed cause of death (Item 23a) (Type, Print)

State Registrar



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - STATE REGISTRAR	O O	CI	ERTIF	ICATE	E OF	DEAT	H		REG. NO.	_				
1. DECEDENT'S NAME (First, Middle, Last)					_	-			TE OF DEATN			3. TIME OF DEATN		
BABY GIRL PAR	K								DIST 20		YEAR	5:50	334	
4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. las	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DA	TE OF BIRTH	19	6. BIRT	HPLACE (St		7
N/A	1 🗆 M 2 💂 F		YRS.	MONTHS	DAYS	HOURS 4	MIN. 14		onth, Day, Year)		Count	**	ZT ANTIN	
9a. FACILITY NAME (If not institution, give s	treet and number)			9b. ÇITY	, TOWN	OR LOCATIO	-	U / E	.0199	NTY OF E	MARYLAND F DEATH			
GREATER BALTIMORE	MEDICAL CE	NTER		ТО	WSON					RE		_		
10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN (OR LOCA	TION				10d. INSI		_		
MARYLAND BA		<u> </u>	LUT		ZIP CODE				t 🗌 YES	2 NO				
4 Hillspoint Co					21093				WHAT COUR	ITRY?				
11. MARITAL STATUS	12. WAS DECEDENT EV	(ED IN II C AC	narn.	T 40							USA			
12 Never Married 2 Married	FORCES? t	YES 2 X			II yea, ap	ecify Cubar	n, Mexicer	i, Puer	GIN? (Specify Yea to Rican, atc.)	or No-	14. RAC Biac	E — Americ k, White, at	an Indian, c.	
3 Widowed 4 Divorced	IF YES, GIVE WAR					2 🔀 NO	Specify	:			Spec	As:	lan	
15. DECEDENT'S EDUC (Specify only highest grade	completed)	(G	CEDENT'S	work done	CCUPATION TO COURT OF THE COURT	ON ast of working	9	1	6b. KIND OF BU	SINESS/INC	DUSTRY			
Elementary/Secondary (0-12)	College (1-4 or 5+)	III0	. Do NOT us	200										
17. FATHER'S NAME (First, Middle, Last)	/A		N/	A					N/A				_	
CHARLES		DADIE							t, Middle, Maiden	,				
19a. INFORMANT'S NAME (Type/Print)		PARK				OK			ARK		PARK			
G.B.M.C. PATHO	LOGY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
20a. METNOD OF DISPOSITION	B001		6701 N. CHARLES ST. TOWSON, MD. 21204.										•	_
1 Burial 2 Cremetion 3 Rem	oval from State	GREE!					ODV	1	3/26 B.					
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEF	GKEE	N MO			D ADDRES		_	0/40 B	ALTC	. , [*]	D.		
Ni Mean C.	land 1			H	ENR	Y W.	JE:	NK]	NS & BALTO				.1	
23. PART i. Enter the diseeses, or o	complications that ca	used the de	eth. Do r										roximate	_
ahock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one ceuse	on each line).										rval Betweet and De	
Alianas an annualist	ov ho	1001	0.	(4.10	2-1							u	M .	
resulting in deeth)	DUE TO (OR	AS A CONSE	DUENCE O	y GYI	101	CV ()	7					1	Zho	AN
							-					İ		
Sequentially list conditions, If sny, leading to immediate	DUE TO (OR	AS A CONSE	DUENCE O	F):								-		
CAUSE (Disease or Injury	C													
that initiated events	DUE TO (OR	AS A CONSE	OUENCE O	F):										
resulting in deeth) LAST	d													
PART II. Other significent condition	e contributing to dec	oth but not r	resultina	in the ur	nderivin	cause o	iven in	Part I.	24s. WAS AN	AUTOPSY	241	. WERE AUT	DORY EINION	100
			-			,	70		PERFOR	MED?		AMILABLE	PRIOR TO ON OF CAUS	-
									1 YES 2	X] NO		OF DEATH	7	
DID TOBACCO USE CONTI	DIDLITE TO CALIC	F OF DEA	TII VE	· C 🗆	No k	11116	EDTA IA					1 TYES	2 📉 NO	
25. WAS CASE REFERRED TO MEDICAL	CIBUTE TO CAUS		E OF DEAT			UNC	EKIAIP	<u>ч П</u>						_
EXAMINER?	HOSPITAL:			OTHER	A:									-
27. MANNER OF DEATN	1 N Inpetient 2 ER		28b. TIM	- Y	28c. INJ		sidenca	_	her (Specify) DESCRIBE NOW II	N diamy oo	CHRED			_
1 🔀 Netural 5 🗌 Pending	(Month, Day, Y			URY	WC	RK7	1 NO	200. 6	ESCHIBE NOW I	NJUNT OC	COMED			
2 Accident Investigation	28e, PLACE OF IN	JURY At ho	me farm	rtraat fact			NO	20/ 1/	OCATION (Street a	and Mumba	ar Duml	Chauta Alumb		_
3 Suicide 8 Could not be determined	building, etc.	(Specify)	- At home, farm, atreet, factory, office					C.	ity or Town, State)	iru Numbei	or mural	route Numb		
29e. CERTIFIER	NAME TO A STATE OF THE PARTY OF	5075G				50.00	270	0.000						_
(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my													
		The state of the s	veageno	, my c	-p-resired 1, 0				iii and biace, en	1 - 1-41	100	7 - N - 1 1 - 1 - 1		
29b. SIGNATURE AND TITLE OF CERTIFIER	1					29c. LICE	NSE NUM	BER		294 DAT	E SIGNED	Month Da	Macl.	

D0053936

Charles St

BeltmD

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Bridget

1999

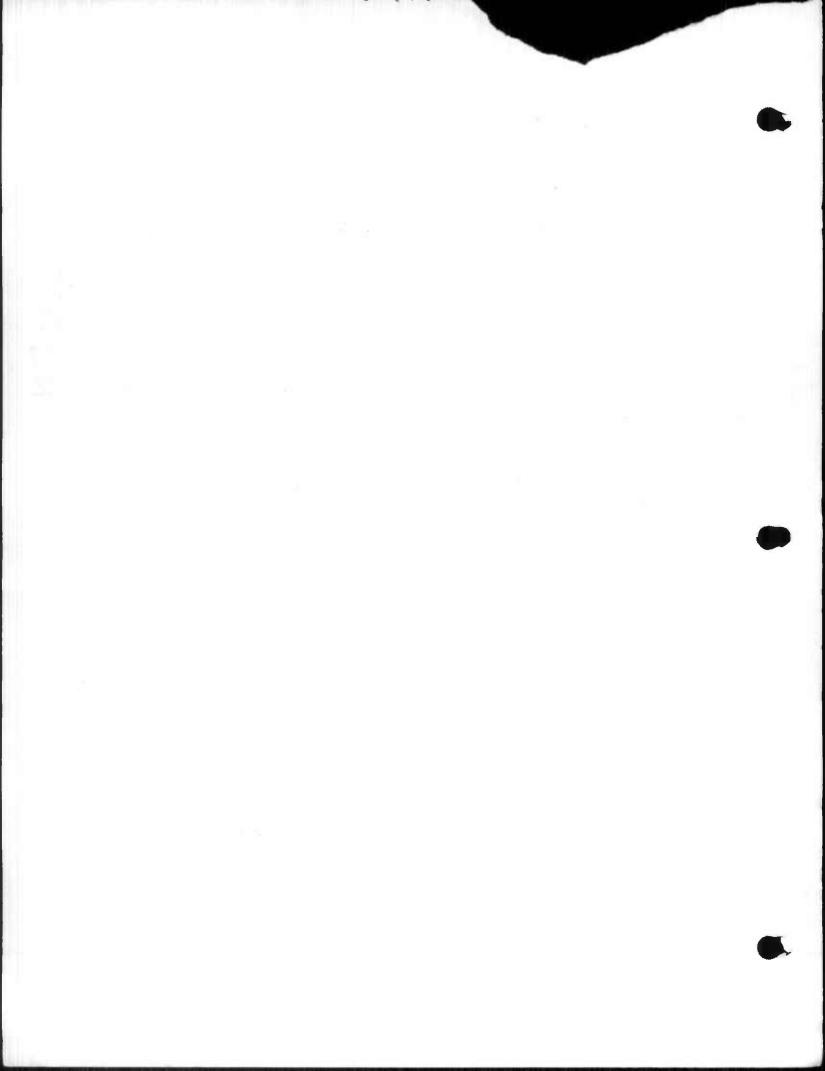
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNERAL DIRECTOR

my LATE

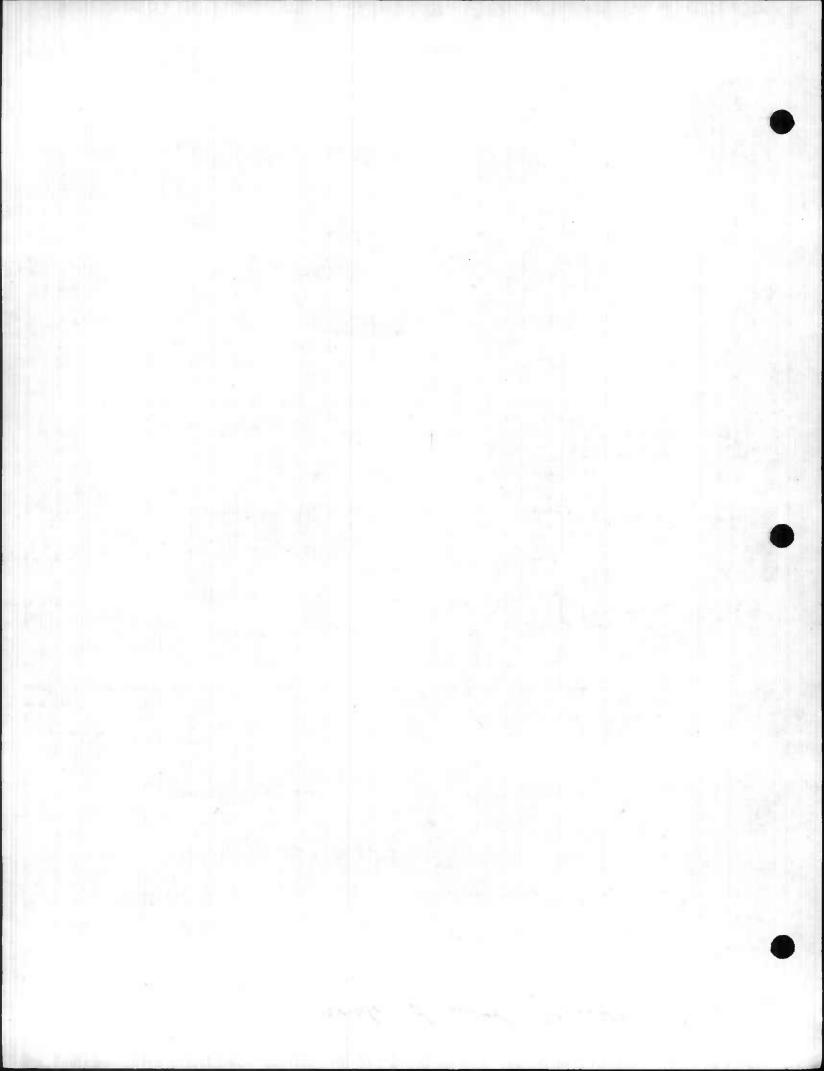
Park, Baby Gir

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State of Maryland / Department of Health and Mental Hygiene

					Certificate of	Death		Reg. No.99	27:	343			
		1. Decedent's Name (First, Middle, Le	est)				2. Data of De Month	ath Day	Year 3	3. Time of Death			
J	Physician /Medical	Will	ie Ray Ro	berts	on, Jr.			7, 199		1:45 PM			
	Examiner	4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death											
		847 Lennox Avenue, Apt. D Baltimore N/A											
	Funeral Director	5. Social Security Number 245-34-8616 6. Sex 70 Yrs. Social Security Number 70 Yrs. FEB 18, 1928 North Carol											
	2 -	Usuel Residence of Decedant											
	aryta dat dat	MD N/A		10c. City, Town						Inside City Limits 1 ☑ Yes 2 ☐ No			
	or 25e-f s be notified Director			ватс	imore			Λ					
	her death or here 23 alone count	11. Merital Status	12. Was Decedent Ex Armed Forces?	ver in U,S.	13. Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecity Yes or No Rican, etc.)		e - American I k, White, etc.	Indian,			
020	Exam Exam by F	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No		The start of the s	Specify		ck			
21215-0020	ed within 72 ho ygiene. wer than "natur it, the Medical. Completed	15. Decedent's E (Specify only highest gro	ade completed)		Decedent's Usuat Occu (Give kind of work done life. DO NOT use retin	ipation during most of work ed)	ing	16b. Kind of Bu	siness/Indust	ry			
212	the start	Eiamantery/Secondary (0-12)	College (1-4or 5+		elief Ope			Chemic	cal Co	ompany			
Maryland	Mental Hygin rhad other alic event, ij	17. Father's Nama (First, Middle, Last Willie Ra		n, Sr.			or's Name (First, Middle, Maiden Surname) Nina Scales						
Mary	ond 2 shoulth and M 27 is mair r traumat	19a. Informant's Name/Ralationship (Sandra R. Graves/					r Rural Route Number, City or Town, State, Zip Code) Statesville, NC28625						
ē,	A Hand	20s. Mathod of Disposition		20b. Place of	Disposition (Name of crematory or other pla		Deta	20c. Location -		Stata			
altimore,	f. Page rhant: if njury or	1 Burial 2 Cramation 3 4 Donation 5 Other (Special Signature of Funeral Service, Lice	y)		Crematory,	Inc. 08/2		Baltin		MD			
Ba	Depa Depa Impo any i	Colward A.	regorchik	K.	Crematic 299 Fred	ess of Eacility On Societ Herick Ro	y of l	Marylar timore	nd, Ir	nc. 21228			
		23a. Part1. Enter the disease, or som shock, or heart failure. List only	ona cause on each line	he death. Do n	ot enter the mode of dy	ring, such as cardiac	or respiratory a	rrest,	tnt	proximata erval Between			
	Physician /Medical Examiner	Immediate Cause (Final diseasa or condition rasulting in death)	Lung C	onlor pue to (or as a c	Spanner a	Al Carain	, Righ	o leng		months			
-	in d		_										
o,	cate be executed physician and s the burial-transit	Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequence of):											
68760,	rificate be ng physicia as the bur												
Box	attending I for use a												
	death d for	Pert II. Other significant conditions of	contributing to death but	not resulting in	the underlying cause of	iven in Part I	23h Did	lobacco usa cor	atribute to the	e cause of death?			
P.0	at the death celetached by the attendireletached for use	. 0		- 1			101	/		ty 4 Unknown			
	igned be del	Chronic Obst	wolou-	almon	1 disen	le .	A						
of Vital Records,	been s should				an autopsy rmed?	availal	autopsy findings ble prior to letion of cause lth?						
æ	The lay ate has page 2						10	Yes 2 No	1 D Y	es 2 No			
ta		25. Was casa rafarrad to medical				26. Place of Deat							
>		examinar?	Hospital:	2 ER/Out	patient 3 DOA	ther		dence 6 Oth	er (Specify)				
	ding Physics. After this funeral distribution: To	27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigatio	28a. Date of Injury (Month, Day		ma of 28c. Injury			how injury occurr					
Division	tal or Attending P rs after death. al Director: After led in by the funer Certification:	3 Suicida 6 Could not b	e One Place of Initia	y - At homa, far (Specify)	m, street, factory, office		28f. Location (: City or Tor	Street and Numb vn, State)	er or Rural Ro	oute Number,			
	Hospi 24 hou Funer tely fill	29a. Cartifiar 1 Certifying Pt (Check only 2 Medical Exer	sysician: To the best of niner: On the basis of a and manner state	xamination and	death occurred at the t /or investigation, in my	ime, data and place, opinion, death occurr	and due to the red at the time,	cause(s) and ma data and place, a	inner as state and due to the	d. e cause(s)			
	To the comple	29b. Signeture end title of certifiar	che,	MO		1815-		29d. Data signed	d (Month, Day	-			
	1 ^	30. Nama and address of person who	completed cause of dea	ath (ttem 23a) (,			, , /				
	NY	Chi-Shiang Che			adway Suit	e 410 Bal	to., MD	21231					
	State	31. Data filed (Month, Dey, Year)	32. Registrar	's Signature	1								
	Registrar	AUG 3 1 199	9 men	2 19	. sparks	/							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death Month

1. Decedent's Nama (First, Middla, Last) **Physician** DOROTHY M. ROPPELT August /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a Facility Nama (If not institution, giva street and number) Examiner Franklin Square Hospital Center Rosadale If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) MARCH 23 1918 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Hours Months 1□ M 2 F 81 MARYLAND 215098628 Director Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location Director MD BALTIMORE or 28a-f s ROSEDALE 10a. Street and Number 10f. Zin Code 10g. Citizan of What Country? 234 7518 BRIGHTSIDE AVE Funeral 21237 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 XX 8 1 ☐ Yas 2 No Specify: Specity. þ 3 Widowed 4 Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grada completed) Decedent's Usual Occupation
 (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 88 Pages 1 and 2 should be next of Health and Mental is marked PAUL HARTMAN MARGARET ARNETT 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Important: If Item 27 any injury or other to 7518 BRIGHTSIDE AVE BALTIMORE, MD 21237 NORMAN J. ROPPELT / HUSBAND 20b. Place of Disposition (Nama of cematary, crematory or other place)
OAK LAWN 20c. Location - City or Town, Stata 20a. Mathod of Disposition ©Burial 2 ☐ Cremation 3 ☐ Removal from State 8/31/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Liga-22CVACH/RUSEDALL FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Finat diseasa or condition rasulting in daath) /Medical Myocardial Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Dua to (or as a consequence of) Box 68760, 4 Dua to (or as a consequence of):

Physician/Medical Completed by Certification: To Be

980

page 2 certificate has

this funeral

After

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3

To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A

death.

Records, P.O.

of Vital Physician:

Division or Attanding Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical examinar? 26. Place of Death (Check only ona) Hospital: 1 ☐ inpatient 2 ★ER/Outpatient 3 ☐ DOA 1 Yas 200 No Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner stated.

29b. Signatura and titla of certifie

29c. License number

29d. Data signad (Month, Day, Year) August 28, 1999

3. Tima of Death

7:41 A.M.

10d. Insida City Limits 1 Yas 2 No

Approximata Intarval Batween Onset and Death

Hour

WHITE

30. Nama and addrass of person y J. Frohna, Franklin Square Hospital Center, 9000 Franklin Square Drive, Baltimore, Maryland 21237 no completed causa of death (ttem 23a) (Type, Print) Dr. William 31. Data filed (Month, Day, Year)

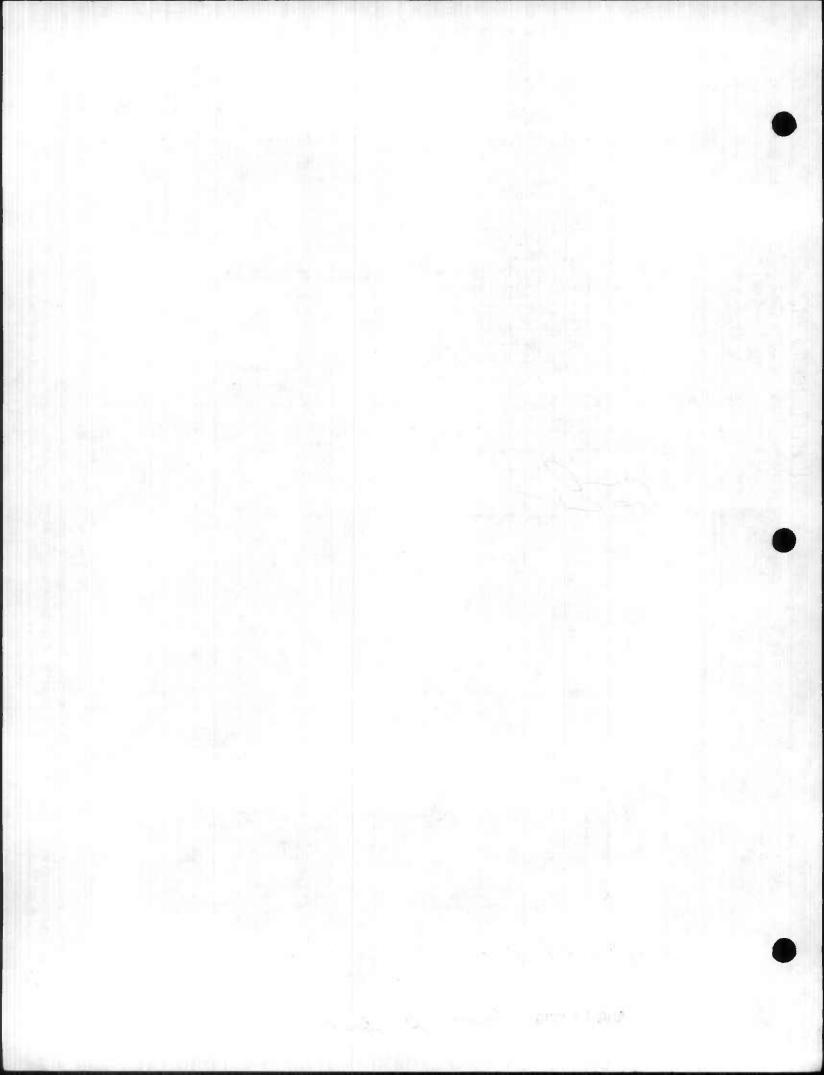
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32. Registrar's Signatura

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 1999 27 0055 **EDWARD** A. ROBINSON · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner ST. AGNES HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 □(M 2 □ F Months Days Hours Min Yrs. 215-60-3906 54 BALTIMORE, MD. AUG 4,1955 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahov traumatic avant, the Medical Examinat must be notified at 1√2 Yes 2 No Directo BALTIMORE MARYLAND 10e. Street and Number 10f. Zto Code 10g. Citizen of What Country? USA AVE. 21229 569 LUCIA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haalih and Mental Hydiene. Important: If Item 27 is marked other than "natural", or fram any injury or other traumatic access. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: AFRO. AMERICAN þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) SHEET METAL FABRICATOR METAL CO. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DOROTHY LUCILLE ROBINSON **EDWARD** MILLS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AVE, BALTIMORE, MARYLAND 21229 ROBINSON WIFE DONNA L. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON RARK CEMETERY 9/2/99 BALTIMORE, MARYLAND 21. Signature of Funeral Servica Licansee ESTEPBROTHERS FUNERALSER. P. A. LLOYD 1300 EUTAW PLACE, BALTI-10RE, ARYLAND.

23a. Part. Ent. the disease, or complications that churred the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical · Advanced carcinoma 6 months Examiner Examiner 6 months cell carcinoma, unknown primary physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): use as I signed by the a d be datached f 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 10 3 Probably 4 Unknown hyperkalemia þ 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? coagulopathy completion of cause of death? 1 Yes 2 □ 1 Tyes 2 No. metabolic acidosis 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending after death. Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 ho To the Fune completaly fi Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 16 Rev 6/95

AUG 3 1 1999

31. Date filed (Month, Day, Year)

Dhy Obs ms

nd address of person who completed cause of deeth (item 23a) (Type, Print)

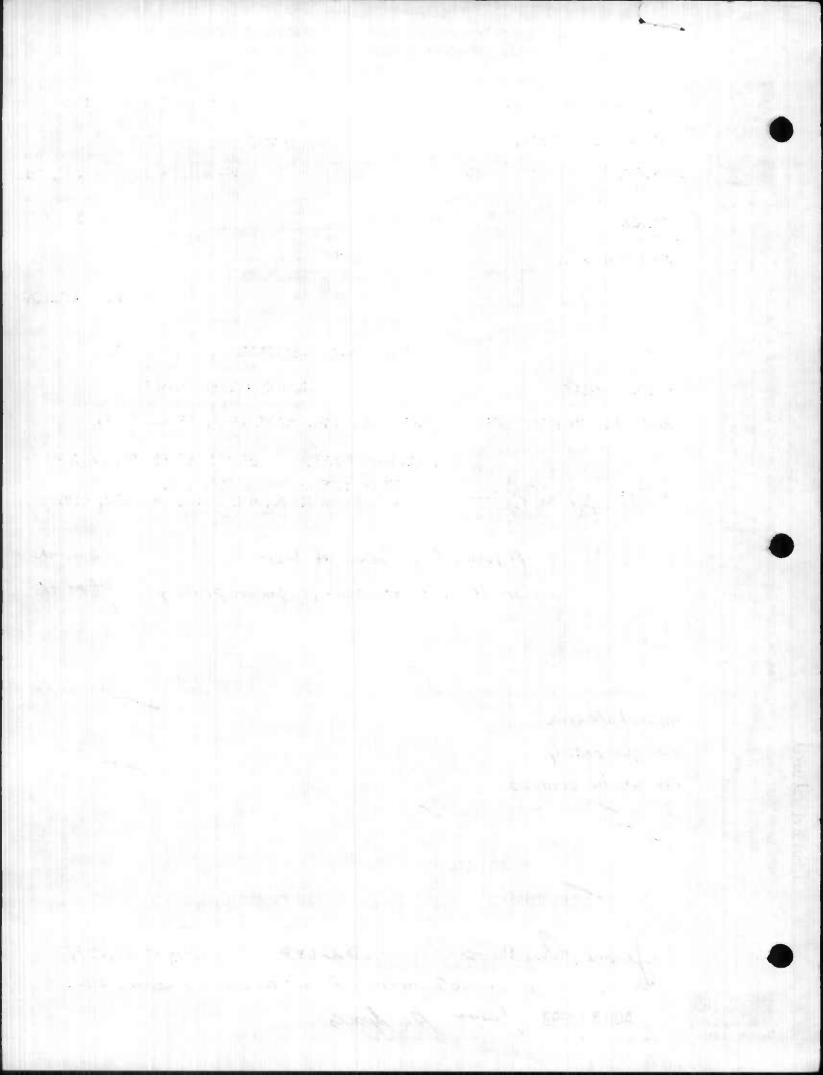
32. Registrar's Signature Lek Sporks

D22648

Jerome I. Snyder m.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

August 27, 1999

Robinson, Edward



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RUTH AUGUST 29, 1999 1:00 PM EDITH RAGUCCI /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 2750 NORFEN ROAD If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Months 1□M 2√2F Deys Hours 76 215-26-9867 DEC. 22, 1922 MARYLAND Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes X No Director MARYLAND BALTIMORE BALTIMORE HIGHLANDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2750 NORFEN ROAD 21227 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 ☐ Merried 1 Yes 2 No If Yes, Give Yeer or Detes; WHITE 1 ☐ Yes 2 XNo Specify: þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be GRAY NETTIE BELLE BRIDGES JOHN WITLITAM 19e. Intorment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MR. KENNETH Z. MILLER (SON) 728 E. MAPLE ROAD, LINTHICUM, MARYLAND 21090 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 8/30/99 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER, LLC SEVENSVILLE, MD. 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Nichsel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete ervel Betw Onset end Death Immediate Cause (Final disease or condition resulting in deeth) CoronaRY Artery Disease years Due to (or as e consequence of): Examiner Essential Hypertension 16 years Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Chronic Obstructive Pulmonary Disease 20 years Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Carcinoma of Breast þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2 € No 1 ∏ Yes 2 ∏ No 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1√ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Naturel 5 Panding 1 ∏ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. edical 29e. Certifier (Check only

The law requires that the death certificate be executed ician and burial-trans Box 68760 the US0 85 1 P.O. Records, page 2 certificate has Division of Vital or Attending Physician: this funeral After after death. filled in by 24 hours a Funeral D Hospital within 2 \$

Funeral

Director

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Pages 1 and 2 should be nent of Health and Mental

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Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year).
AUG 3 1 1999

one)

29b. Signature and title of certifier

Harjit

Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225 32. Registrar's Signeture

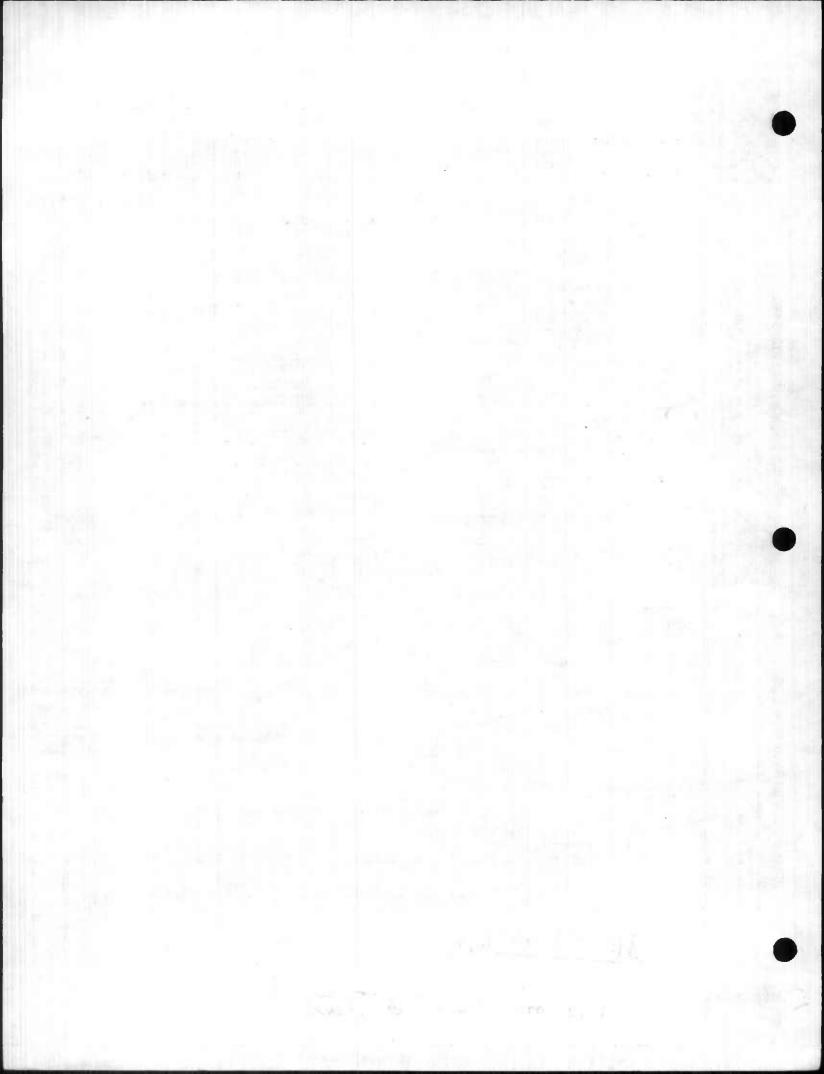
30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

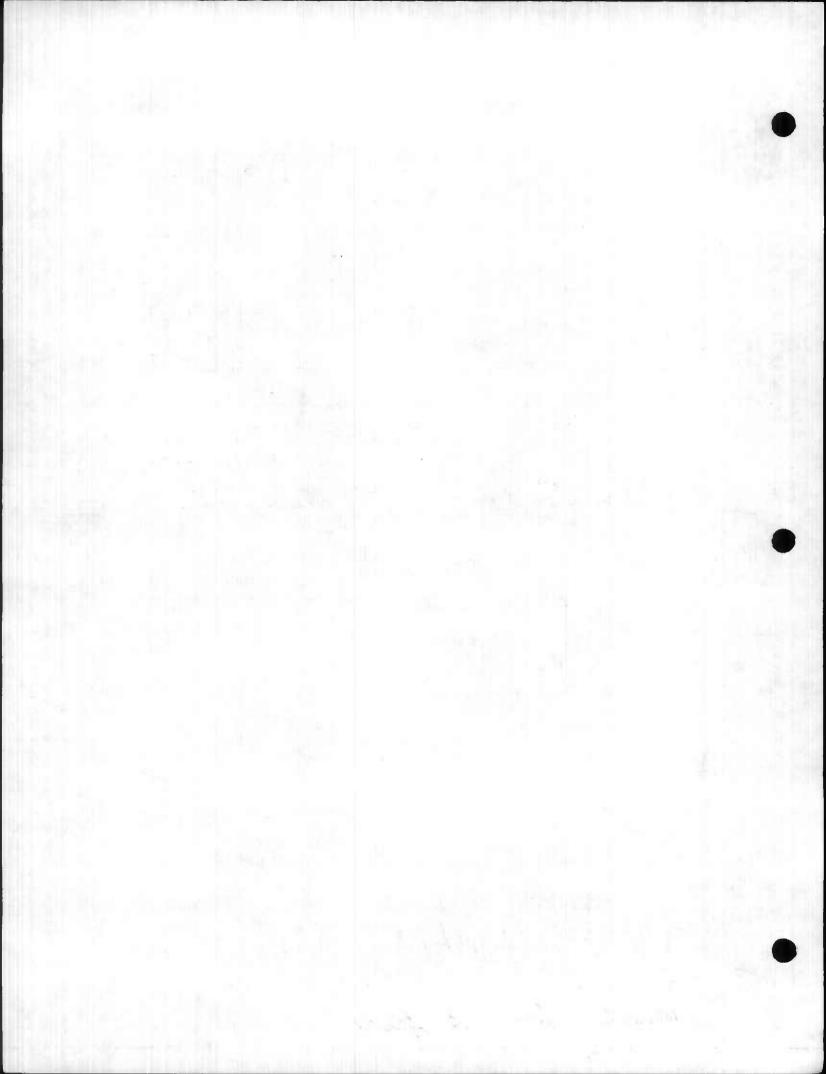
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29d. Date signed (Month, Day, Year)

08/30/1999



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	Physicia		Decedent's Name Leonard			nhar	dt					2. Dete of De Month August	Dey		ear 99	3. Time of Death 2:45 am	
	/Medica Examine		4a Facility Neme (#	not institution, giv	e street end na	umber)				- 1	4b. City, Town, or I			County of		2.45 am	
	Funeral Director		Chesapeake Hospice House 5. Social Security Number 137-07-9054 Laure Residence of December 101 M 2 F 90						Month	ler 1 Year s Deys	Linthic If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, De				Arundel , 9. Birthplace (State or Fóreign Country) Lithuania	
	p R s	-	Usual Residence of I 10a. State	Decedent 10b. County			10c. City, T	Town o	r Location						10	0d. Inside City Limits	
	th the Maryland or 28a-f show to notified at	ţŏ	FL	Pinellas	3		Lar	ao.								1 ☐ Yes 2X No	
	h the	Director	10e. Street and Num				201	90	101. 2	ip Code			10g. Citi	zen of Wha	t Coun	try?	
	2 24		316 Ced	lar Lane						33540			US	A			
020	Exemple 1	by Funeral	11. Marital Status 1 ☐ Never Merrie 3 ☑ Widowed 4		12. Was Dec Armed F 1 X Yes If Yes, G Year or I	orces? 2 ☐ No ive			13. Was Dec ff Yes, sp 1 ☐ Yes	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	es or No- etc.) 14. Race - American Indian Bleck, White, etc. Specify: White			etc.		
21215-0020	within 72 ho ens. than "natur he Medical	Be Completed	(Specification (Speci	15. Decedent's Ed y only highest gradery (0-12)	ducation de completed, College		-)	(C	ecedent's Us live kind of a le. DO NOT	vork done	during most of wor	king 16b. Kind of Business/Industry Aerospace					
0	o filed other rent, 1	č	17. Father's Neme (F	First, Middle, Last,)			9-			18. Mother's Ner	ne (First, Middle			100		
Maryland	and 2 should be saith and Mental n 27 is marked o ser traumatic eve	LO B	Carl Re	inhardt							Kasmir	a Masai	tis				
any	2 sho and h is ma		19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rura														
	and lealth m 27 her tr	-		Reinhardt	(Son)						nding Dr		-	_			
altimore,	Pages 1 nent of H ent: If the ary or of			osition Cremetion 3 Other <i>(Specif</i>		Stete	cem	etery,	isposition (A cremetory of on Cet	r other ple		Dete 09/07		ny Ne		wn, Steta Tersey	
Baiti	permit. Departri Imports any Inju		21. Signeture of Fun	eral Service Licer	nsee 7	/	10				ess of Fecility Funeral	Home, H	P.A.				
	Physician /Medical Examiner	Je	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	feilure. List only	one ceuse on	each line	э.		enter the m	ode of dyin	ly Avenue	or respiretory	errest,		1	Approximate Interval Between Onset and Deeth	
68/60,	ficate be executed physician and as the burial-transit	8	b														
ROX	death certifi e attending ed for use as	Physician/Me	d														
	death	SICIA	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.									23b. Dfd	23b. Dfd tobacco uss contributs to the cause of death?				
, F.O	es that the death certific igned by the attending is be detached for use as	Dy Pmy									10	Yes 2	□No 3	□ Prot	pably 42 Onknown		
ecords,	e law requires that has been signed by ge 2 should be dete	Completed										24e. Wes	s an autop ormed?	sy 2	ave	ere autopsy findings silable prior to mpletion of cause deeth?	
II II	The It	5										10	Yes 2	₹No	1	Yes 2□ No	
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SION OT	this aldi	ation: 10	1 Yes 2 R 27. Menner of Death 1 Auturel 2 Accident	5 Pending investigation	28a. Dete (Mor	Inpatien of Injury oth, Day		VOutpe lb. Tim Inju	e of	28c. Inju	4 LI Nursing H	lome 5 Res 28d. Describe		y occurred		House	
DIVISION	tal or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Pleci								f. Location (Street end Number or Rural Route Number, City or Town, Stete)				
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29e. Certifier 1 (Check only 2 one)	☐ Contitying Ph	niner: On the b	e best of pasis of e nner stet	xaminetion	dge, d and/o	eeth occurre r investigetio	on, in my o	me, date and plece pinion, deeth occu	, end due to the cred at the time,	ceuse(s) , date end	end menn plece, and	er es st i due to	ated. the cause(s)	
	o d with	2	25th. Signature and to	MFM	entfr	7	mh	Fr	ulin	9c. Licens)17965		29d. Det	e signed (F	Month, 1	Doy, Year)	
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State of Maryland / Department of Health and Mental Hygiene

O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUG 29, Rosalind Frances Sunstrom 1999 1:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5103 Circle Place Arbutus Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 219-28-5321 65 Director FEB 9, 1934 Maryland Usual Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ma 23a or 28a-f ahov 1 ☐ Yes 21 No Director Baltimore Arbutus 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5103 Circle Place 21227 Funeral USA Nema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, r than "natural", or here Biack, White, etc. Peges 1 and 2 should be filled within 72 hours after nant of Health and Mental Hygiene. Int: If Item 27 te marked other than "natural", or Ite 1 Yes 2 No 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White Be Completed by 3 Widowed Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Customs Aid Federal Government Baltlmore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Ellsworth Scott Sunstrom Dora Elizabeth Horsey 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) or other tree P.O. BOX 863 Severna Park MD 21146 ecc of Disposition (Name of Date Date 20c. Location - City of Town, State Ann Coscia/daughter 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removel from State Department of important: If any injury or page. 4 Donetion 5 Other (Specify) Metro Crematory, Inc. 08/30/99 | Baltimore, MD 21. Signature of Funeral Service Liberal 22 Name end Address of Facility Cremation Society of Maryland, Inc. egorchik Frederick Rd. Baltimore, MD 21228 or corplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, that only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) l year Metastatic Lung Carcinoma Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): and Box 68760. Physician/Medical tha Due to (or as e consequence of): 080 signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata funeral director, Be 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury st Work? 28d. Describe how injury occurred 28b. Time of After 1 Netural 2 Accident 5 Pending 1 Yes 2 No deeth. investigetion within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homlcide Hospital 29e. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and menner steted. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier Plelo Collocel compacts flex 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) HIHGWAY TICHIE CHVVARIZ MICHAEL 31. Date filed (Month, Day, Year)

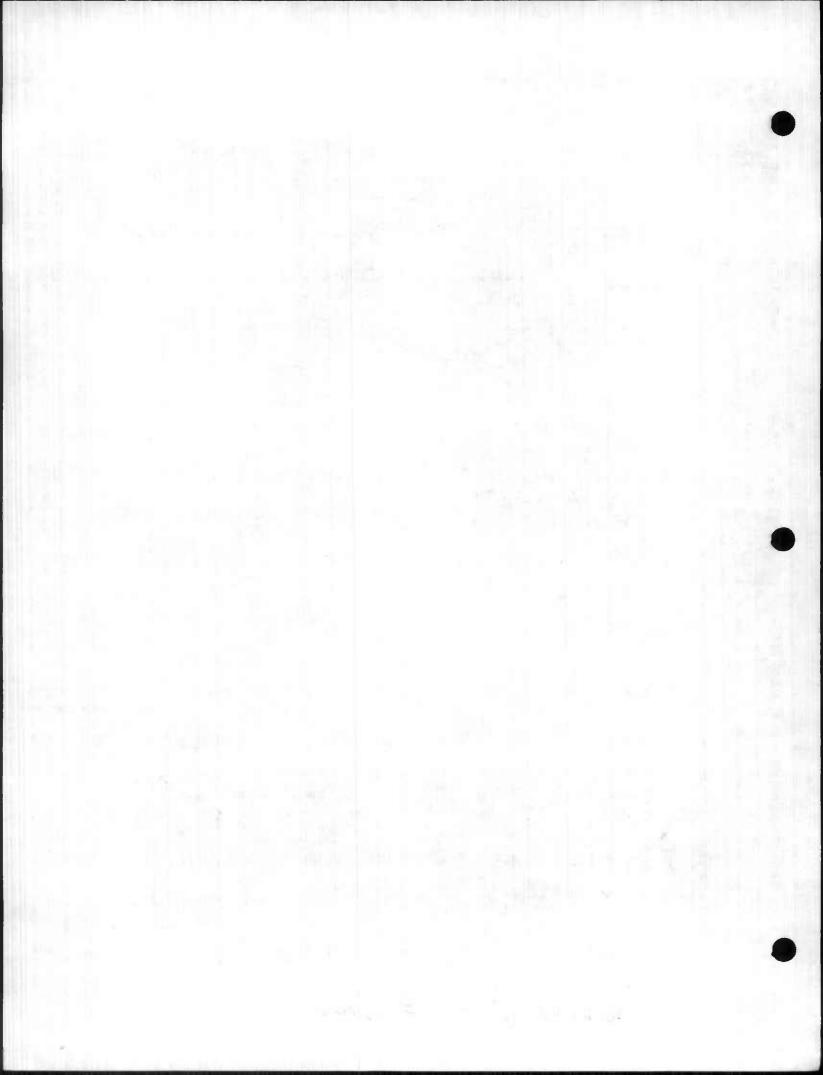
DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

AUG 3 1 1999



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 2^{Day}, Month Physician Frank J. Schaum, Jr. 1999 7:15 A.M Aug /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel General Hospital Annapolis Arundel Anne If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dala of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Hours 1 MM 2□ F Months Director 217-40-5279 56 12,1943 Maryland Usual Rasidence of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 262 Ullman Rd 21122 U.S.A.

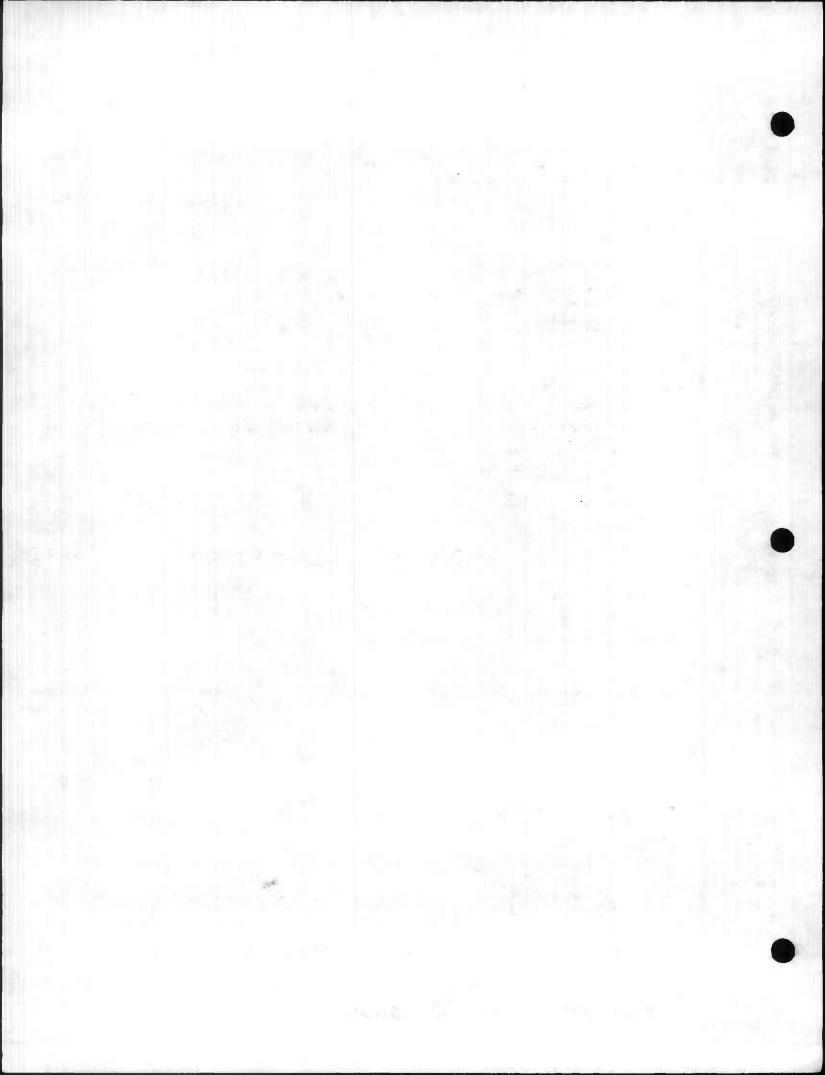
14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yas 2 No
If Yas, Give
Year or Dates: Bleck, White, atc. 72 hours after 1 Nevar Merried 2 Married 1969 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced White "natural", 1970 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72. Department of Heelih end Mental Hyglene. Important: if item 27 is marked other than "nat, any injury or other traumatic event, the Medical DRDS. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Salesman 4 G.P.A. Hobbie 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Be Frank J. Schaum, Sr. Marquerite Ricciuti 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 262 Ullman Rd. Pasadena, Maryland 21122 Laurie B. Schaum (Wife) 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burlat 2 M Cramation 3 ☐ Removal from Stata Greenmount Cemetery 8/28/99 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Pert1 Phiar tha disaasa, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona causa on each fina. Approximata Intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical LUNG CANEGR HTUOW! **Examiner** Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burishmans Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) 950 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 10 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy peed has 1 ☐ Yas 2 No 1 ☐ Yes 2 No certificate Hospital or Atlanding Physician:
 24 hours after deeth.
 Funeral Director: After this certifical letely filled in by the funeral director. 25. Was casa refarred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 2 Ccident 5 Pending invastigation 1 Yes 6 Could not be detarmined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and lifts of certifier ANNAPOLIS, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRAZE 900 BESTGATE RD. SUITE 300 TER MD 21801 31. Date filed (Month, Day, Year, AUG 3 1 199) 32. Registrar's Signatora State

DHMH 16 Ray 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 230 ugust Frances V. Sanda 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) laryland ospital Baltimore CIT Greneral N/A If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Deys Hours 1□M 2XF 217-16-4440 76 1923 Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6813 Everall Avenue 21206 u. s. A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Frank Gottal Rose Sekora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) John F. C. Sanda (Son) 4103 Maureen Lane, Fairfax, Virginia 22033 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/31/99 Baltimore, Maryland Bohemian National 21. Signatura of Funaral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. mars 3331 Brehms Lane, Baltimore, Maryland 21213 Approximate Approxima 23a. Part1. Enter the disease of the street tions that cause shock, or heart failure. It is only one cause on each Approximata Intarval Batwean Onset and Deeth . Septic SI Immediate Cause (Final disease or condition resulting in daath) Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury Due to (or as a consequenca of) that initiated events Due to (or es e consequença of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 0 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Piace of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

attending physician and for use as the buriel-transit thet the death certificate be axecuted signed by t page 2 funerai

Physician-

/Medical

Examiner

Funeral

Director

r 28a-f ahow ahow

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be

Peges 1 and 2 should be filed nent of Health end Mental Hygi-int: If item 27 is marked other

permit. Peges 1 and 2: Department of Health er Important: If Nem 27 is any injury or other trace

Physician

Examiner

Physician/Medical Examiner

by

Completed

Be

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Certification:

Medical

4 Homlcida

29b. Signature and titla of certifian

29a. Certifier (Check only one)

/Medical

Rances

Directo

Funeral

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Completed

filed within 72 hours efter death with the Meryland

DivIsion of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. filled in by

> State Registrar

Samuar BHOTT MNILA SARWAR
31. Date filed (Month, Day, Year)

29c. Licanse number

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and dua to tha cause(s) and manner as stated.

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29d. Date signed (Month, Day, Year)

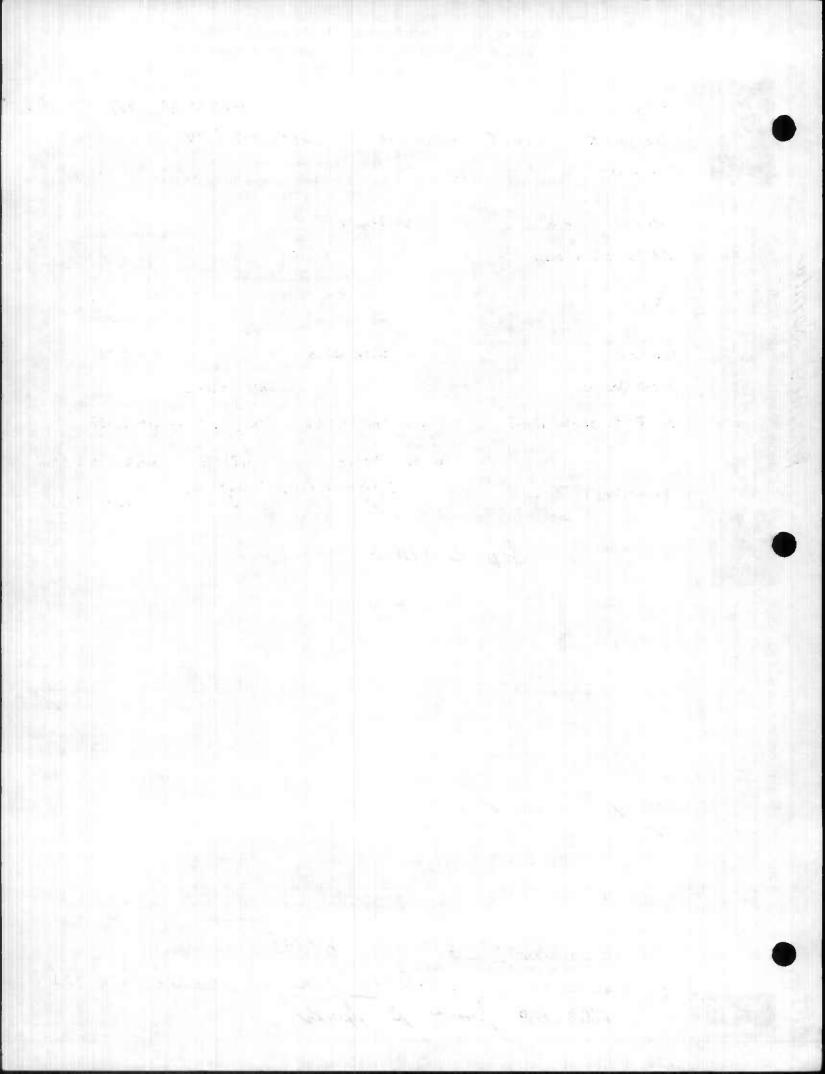
30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

m.D.40

AUG 31

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0030 1999 ROBERT PAUL SNEDDON August 28 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 920 Hours Months 1♥M 2□F Massachusetts 78 Yrs. 011-14-8560 Usual Residence of Decedent 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Forest Hill Maryland Harford 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 C. Kimary Court 21050 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Maritel Stetus Biack, White, etc. 1 (X) Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1942-46 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 4 years Financial Credit Manager Trading Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David MacDougall Sneddon Margaret Cameron 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Sneddon (Wife) 201 C. Kimary Court, Forest Hill, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removel from Stete Dulaney Valley Mem. Gardens 8/31/99 4 ☐ Donation 5 ☐ Other (Specify) Timonium. Maryland 22. Name end Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signeture of Funerel Service Licensee 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. · Acute Myocardial Infunction Immediate Cause (Finel Seconds disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

sportant: If item 27 is marked

Physician

/Medical

Examiner

Funeral

Director

Nerna 23a or 28a-f show

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altimore, Maryland 21215-0020

Director

Funera

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Completed

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Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-trans Be Completed by Medical Certification: To After death. 24 hours after deat Funeral Director:

Division of Vital Records, P.O. Box 68760.

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						24a. Wes an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death? 1 Yes 2 No		
25. Wes case referred	to medical				26. Place of De	eath (Check only one)			
examiner?		Hospitel: 1 ☐ Inpatient 2 5	VER/Outpatient 3	Home 5 ☐ Residence 6 ☐ Ot	me 5 Residence 6 Other (Specify)				
27. Menner of Daeth 1 VNetural 5 2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe how injury occu	rred		
3 ☐ Suicida 6 4 ☐ Homicide	Could not be determined	28a. Place of Injury - At I building, etc. (Speci	nome, farm, street,	fectory, o	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 15 (Check only one)	Certifying Phy Medical Exam	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death occ ation and/or investi	curred at t gation, in	the time, date and place my opinion, deeth occ	e, and due to the cause(s) and m curred at the time, date and place,	anner as stated. and due to the cause(s)		

State Registrar

To the Fune completely f To the Vithin 2

31. Dete tiled (Month, Day, Year)

29b. Signatura and titla of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Haswill 2 North Avenue North 32. Registrer's Signature

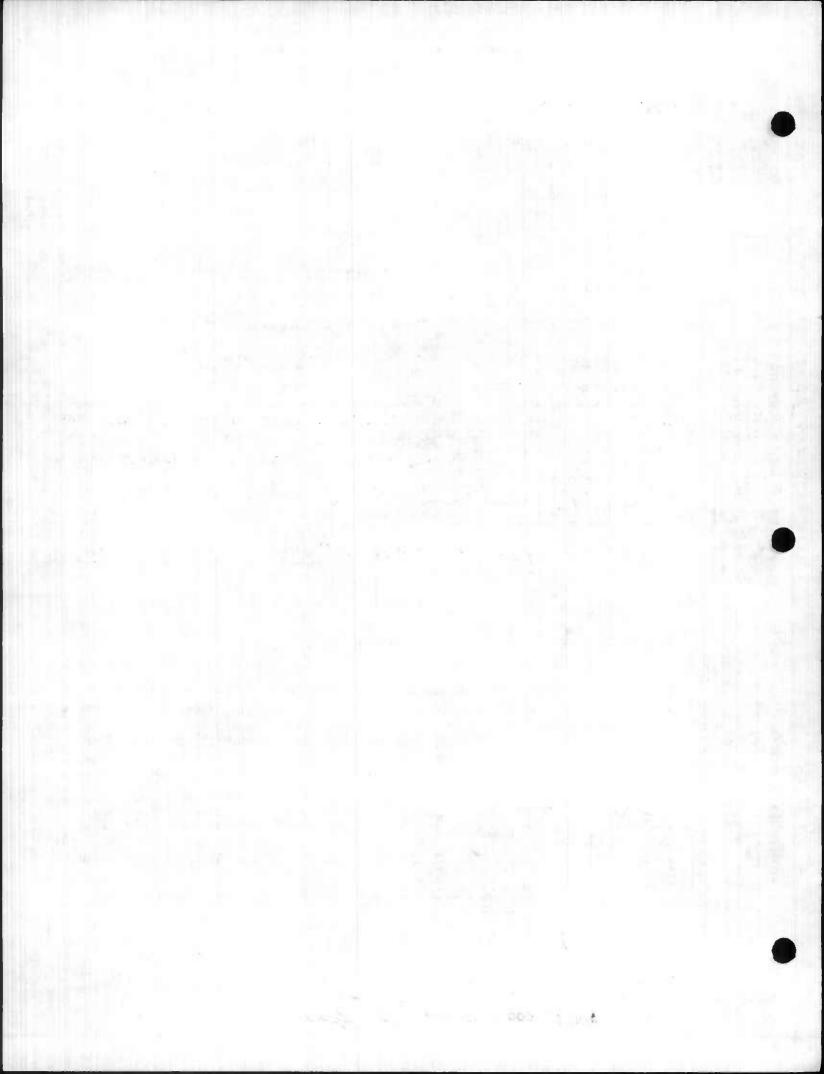
MD

29d. Data signed (Month, Day, Year) August 28, 1999

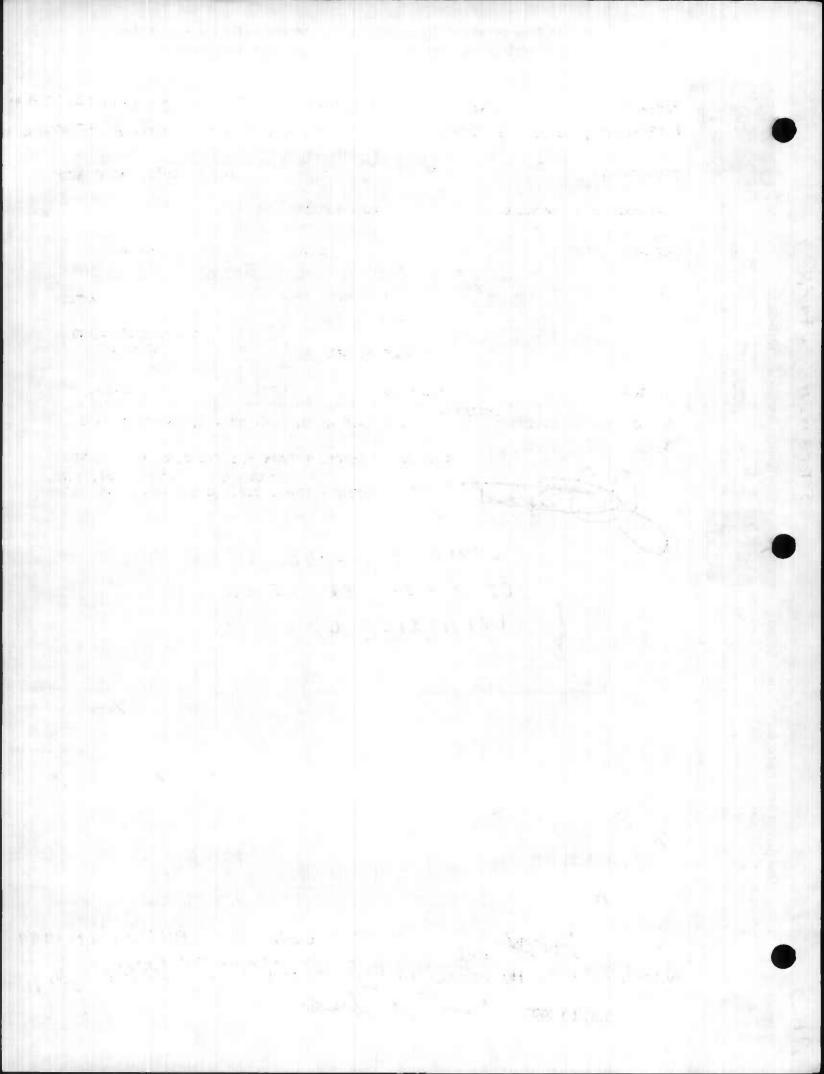
Mury lund 21014

29c. License number

D34652



				Certifi	cate of	Death			Reg. No.	Ga.	1006.		
Physician	Decedent's Name (First, Middle,	Last)						2. Data of De Month	Day	Yaar	3. Tima of Death		
/Medical	JEFFREY							HUGU	ST 29	1999	12-02 A.		
xaminer	4a Facility Nema (If not institution, s	BL HOST	TTAL			GLB	or 13	Cation of Deat		NE (ARUNDEL		
neral ector	5. Social Sacurity Number 6 216-62-1471 Usual Rasidanca of Dacedant	Sax 7. 10XM 2□F	. Aga (In yrs. last bir 42		Under 1 Yaar onths Days			8. Date of Bir (Month, Do	rth ay, Yaar) ', 1956				
lor lor	10a. Stata 10b. County	ARUNDEL	10c. City, Town		n LEN BUI	RNIE		10d. Insida City Limits 1 □ Yas 2 % D No					
ust be notified at ral Director	10e. Street and Number 502 MAYO ROAD			10	Of. Zip Code	21061			10g. Citizen of What Country?				
Examiner must be notified by Funeral Director	11. Manital Status 1 ☑ Navar Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	INO No	If Yas	Decedant of s, specify Cub	oan, Maxicai	n, Puerto I	ocify Yes or No Rican, atc.)		ean Indian, etc.			
Be Completed	15. Decedant's (Specify only highast)	Education grada complated)	16a.	(Giva kind	s Usual Occu of work dona IOT usa retire	during mos	st of worki	ng		16b. Kind of Business/Industry			
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	17. Fethar's Nama (First, Middle, La	st)				18. Moth	er's Nema	(First, Middle	ı, Maidan Sumar				
5	WILLIAM 19e. Informant's Name/Ralationship	I.	STIE		Idrace /Ctros		TCHA		per, City or Town	BALA:			
To Be Comp	MR. WILLIAM I.	(E.Z	ATHER)						, MARYLA				
ă	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe		ata	ry, cramatoi	y or othar pla		ARK 8	Date /31/99	20c. Location GLEN BU				
any injury pose.	21. Signature of Ameral/Service Li		1	/ 22. Na	me end Addr	ass of Facili	ySINC	GLETON	FUNERAL	HOME			
use as the buner-transit	Sequentially list conditions, if eny, leeding to immediate causa. Enter Undertying Causa (Disaasa or Injury that initieted events rasulting in deeth) Last		Due to (or as a company) Dua to (or as a company) Dua to (or as a company)	SIS consequand	OF ca of):	· L.	IVE	ER					
by Physician	Pert II. Other significant conditions	ivan In Part	1.	23b. Did tobacco use contribute to the cause of									
Completed by Physicia	24e. Was an a performed									av	fera autopsy findings reilable prior to implation of cause daath?		
Com								10	Yas 2 No	11	Yas 2 No		
ral director, page : To Be Com	25. Was casa rafarred to medical axaminar? 1 Yas 2 No	Hospitel:			T 504 0	thar:		(Check only		(C	4.1		
tion: To	27. Mannar of Death 1 Neturel 5 Panding 2 Accident invastiga	28a. Date of (Month,		Tima of injury	28c. Inju	4 L N			idenca 6 🗆 Ot how Injury occu		ny)		
completely filled in by the funera Medical Certification:	3 Sulcide 6 Could no 4 Homlcide detamin	not be						28f. Location City or To	(Streat and Num own, Stata)	ber or Rur	al Routa Number,		
etely fille dical C	29a. Certifier (Check only one) 1 Cartifying 2 Medicat Ex	Physician: To tha b aminer: On the bas and manna	est of my knowledge is of axaminetion an ar statad.	e, daeth occ d/or Investi	urred et the t gation, in my	ime, dete er opinion, dae	nd plece, o	end due to the ad at the time	cause(s) and m , date end placa	enner as s	stated. o tha causa(s)		
completely filled in by the f	29b. Signature end titla of certifiar	Wood,	m, D		29c. Lican D 5	sa number	4		PVG (ed (Month,	Day, Year) 29 1999		
	30. Name and eddrass of person with PRVND	to completed causa	of daath (Item 23a)	(Type, Brin	bsPif	HIPDA AL DA	TYE	ARE	公的限	X器	mp (1		
State Registrar	31. Data filad (Month, Day, Year)	32. Rej	gistrar's Signatura	4 .	Sport	les					21001		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔍 🔍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month STEFFENS 27, ALAN 1999 12:45 PM August 4a. Fecliity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Gilchrist Center Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1□ M 2 🔭 F Yrs 215-32-7494 July 2, 1934 Md. Usual Rasidenca of Decedent 10a. State 10b. County 10d. Insida City Limits 1 ☐ Yaa 2 XNo Baltimore Cockeysville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5B Meadow Grass Ct. 21030 USA 12. Was Decedent Ever in U,S. Armad Forces? 1 ☐ Yes 2 [X] No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ho Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Sales Real Estate 12 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Talbot Smith Betty Beckhart 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) Mr. Scott T. Nicklas/son 2700 Hunting Ridge Ct. Baldwin, MD. 21013 20b. Place of Disposition (Name of cemetery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 8/31/99 Timonium, MD. 22. Name and Addrass of Facility Ruck Towson Funeral Home, INc. 1050 York Rd. Towson, MD. 21204 enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Entar the disaasa, or complications that caused the death. Do not ental shock, or heart failura. List only one cause on each line. Onset and Death Immediata Cause (Final 18 month disease or condition rasulting in daath) Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco uas contributs to the causs of death? Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings avelleble prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case rafarred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 25 No Othar: 4 Nursing Home 5 Residence 6 NOther (Specify) 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicida

The law requiras Division of Vital

this certificate has or Attending Physician: after death.

Olrector: After this certifica To the Hospital of within 24 hours a To the Funeral C completaly filled

Examiner Physician/Medical by Completed Be Certification: To

Physician

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Director

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Department of Heelth a Important: If itam 27 is any injury or other tra

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Pages 1 and 2 should be

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29a. Certifiar

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State Registrar

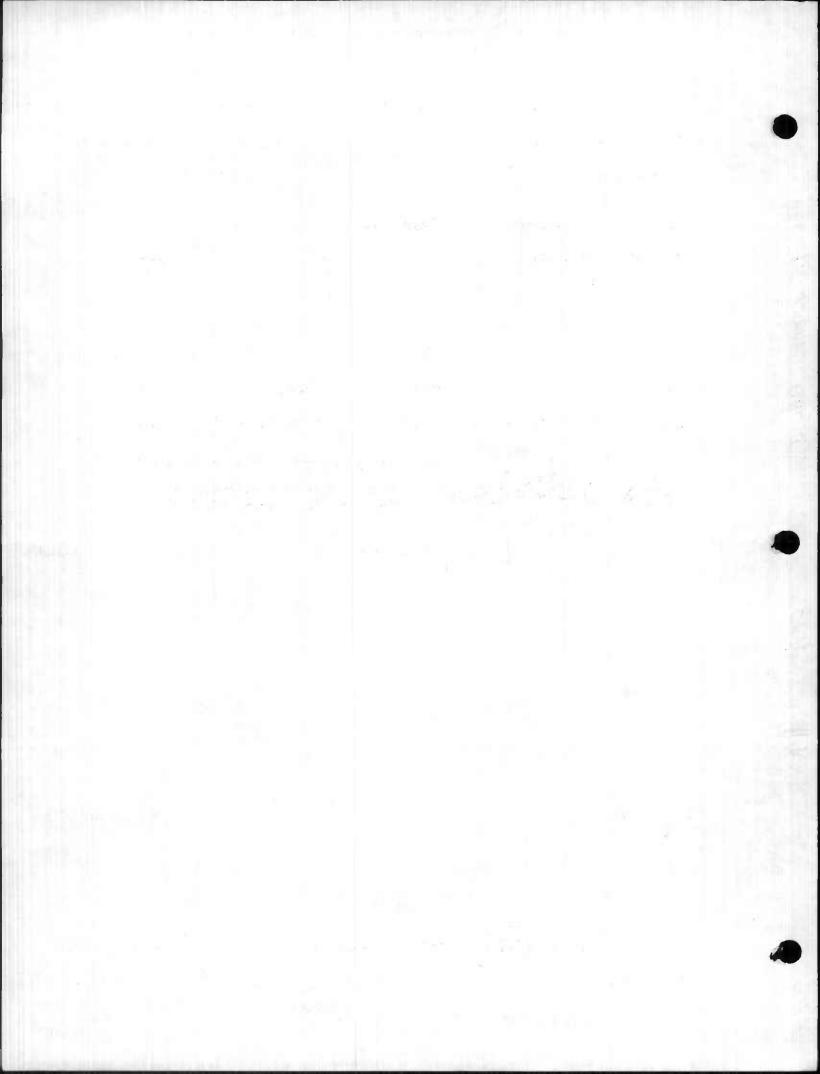
🕊 Certifying Physicfan: To tha best of my knowledga, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ompleted caus laath (Itam 23a) (Type, Print)

G4MC 6701

N. Chales St. Balto, md 21204



State of Maryland / Department of Health and Mental Hygiene

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	ASP	Certificate of Death Reg. No.												
		1. Decedent'a Nama (First, Middle,	Last)							2. Date of De	eath		3. Tima of Death	
ш	Physician	JAMES ANTHONY					Month AUGUS'I	Day 26 1						
	/Medical	4a Facility Nama (If not institution,		T	4b. City. To		ation of Deat		26 1999 235 4c. County of Death					
d	Examiner	PIKESVILLE NUF								E	BALT	Ξ		
-			Sex	7. Age (In yrs.	lest hirthday)	If Under 1	Year			B. Data of Bir	th	place (Stata or Foraign		
	Funeral		10 M 2□ F	7.7	Yrs.	Months	Days	Hours	Min.	(Month, De	ay, Year)	Cou	ntry)	
	Director	134-14-1209 Usual Residence of Decedent	/3							May 2	1926		NY	
d 21215-0020 filed within 72 hours after death with the Manyland Hygiene. ther than "naturel; or Items 23s or 28s-f show int, tre Hedical Examinar mass be notified as	Pu B	10a. State 10b. County		10c. C	ity, Town or Lo	cation						T.	10d. Inside City Limits	
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	vith the Mar or 28a-f all be notified Director	MA Jamica	Plain_		Bosto									
	Dir.	10e. Street and Number				10f. Zip 0	2009				10g. Citizen of	atry?		
	23a	75-A South Stre						02130				S.A.		
	r tems 234	11. Marital Status	12. Was Dec	edent Ever in U proes?	J,S. 13. V	Vas Decede Yes, specif	int of h	dispanic Original Mexican	gin? (Spec	cify Yes or No Rican, atc.))- 14. Ra	ce - Americk, Whita,	can Indian, atc.	
0	or h		1 (X) Yes If Yes, Gi			☐ Yes 2					Specil			
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8			elly					Mary	Powe	ers				
Maryland	d 2 should be the end Mentel of 1a marked of traumatic every traumatic every To Be	19a. Informant'a Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	- Y			er, City or Town	State, Zij	o Code)	
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	Mospital 24 hours Funeral letely filled	29a. Certifier 1 Certifying (Check only 2 N Medical Ex	Physician: To the aminer: On the ba	asis of examina	owledge, death	occurred at	the tie	me, date an	d place, as	nd due to the	cause(s) and m	anner as s	itated. to the cause(s)	
	Per Per Per Per Per Per Per Per Per Per	one)	and man	ner stated.			,							

State Registrar

DHMH 16 Rav 6/95

29b. Signal

31. Date filed (Month, Day, Year)
AUG 3 1 1999

32. Registrar's Signature

G. Sports

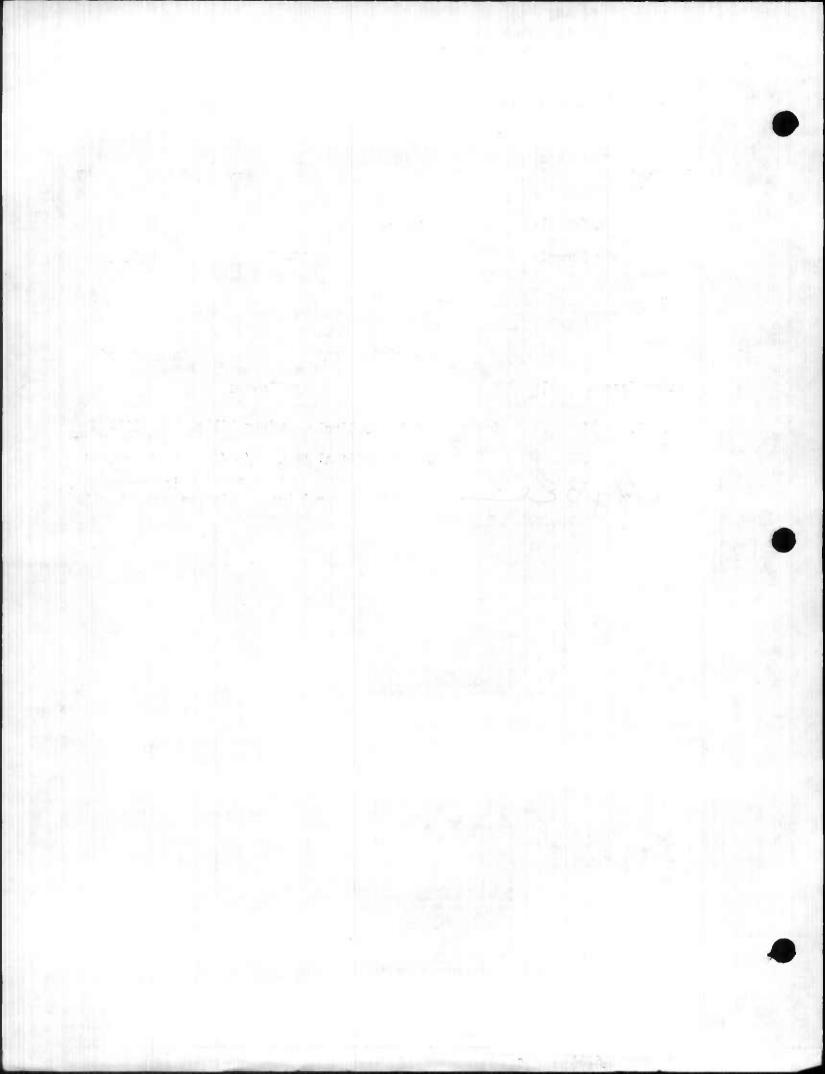
29c. License number

O.C.M.E

ol death (Nem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

AUGUST 27,1999



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Simon AUGUST 1:39 AM 26,1999 /Medical 4e Facility Name (If not institution, give s et and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Mercy owson If Under 24 Hrs. Maris 7. Age (In yrs. last birthday) 19 Yrs. If Under 1 Ye Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Hours 1 M 2 □ F 010-24-0246 Director Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Md Baltimore 1 Yes 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 23 Park way , 5 21216 Funeral tolls nwunns 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hems 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 Merried 1 X Yes 2 If Yes, Give Year or Detes: 2 No specify: Black altimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Foremost Mc Kesson 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) Salesman College wholesaler 2th grade Department of Health and Mental High important: If New 27 is marked other any Injury or other treasment 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) a Simon Cotton Alcibiade Georgia 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roth Leslie Wwashington, D.C. 2 Dete 20c. Location - City or Town, State Son 20036 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removet from State Memorial Park 4 Donetion 5 ☐ Other (Specify) butes 22. Name and Address of Facility Garde West 21. Signeture of Funerel Service Licensee 2/2/5 300 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Da 140, 40 Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel Surcom Metastatio disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): for use as 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown signed be det Aq 24b. Wera autopsy findings evailable prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 26. Place of Death (Check only one) STELLA MARIS AT MERCY Attending Physician: director. 25. Was case referred to medical axeminer? Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? After Netural 5 Pending death. n 24 hours after death. The Funeral Director: All pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide ŏ Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely within 2 To the 29b. Signaty/a and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 3 1 1999

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Durid 10050000 301 54 Paul P1 32. Registrar's Signature

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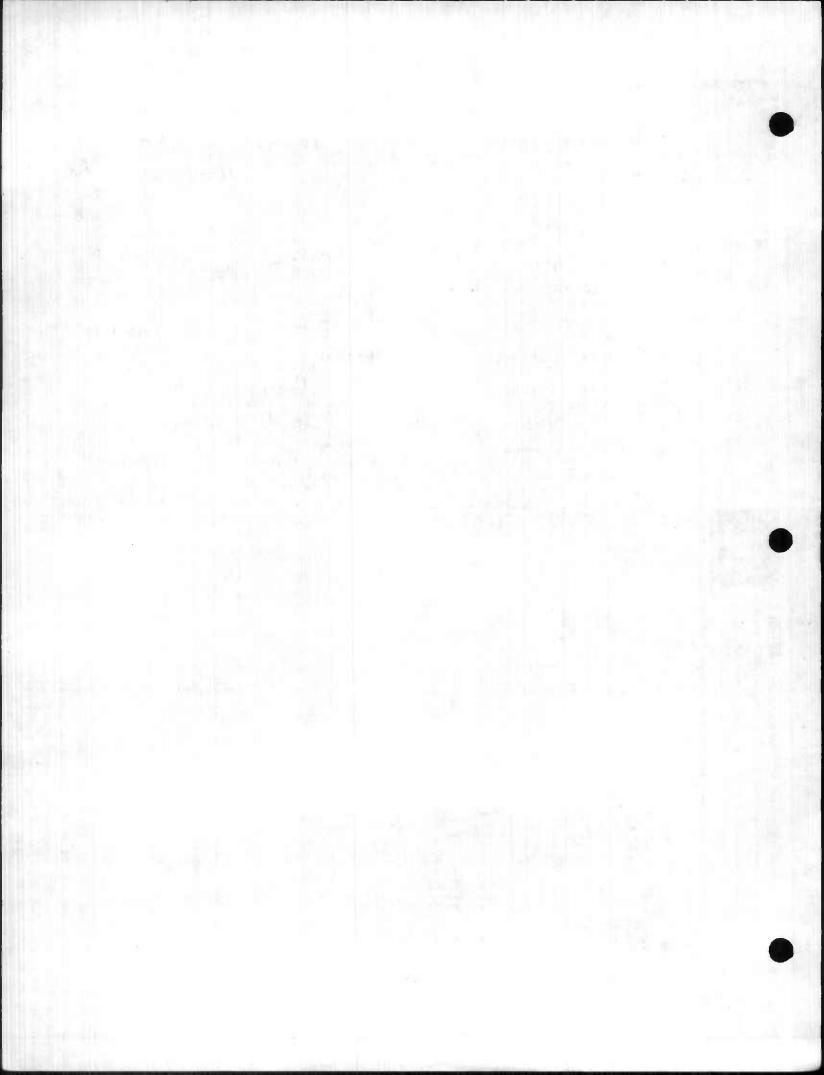
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1, Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** August 28, 1999 3:45pm RICHARD OLIVER THIESSEN /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 219-30-9807 Director 12/14/34 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes ZX No BALTIMORE HILLENDALE Director 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 8321 HILLENDALE ROAD 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1957-1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Yaer or Detes: 1961 Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER YEARS would be fit. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OLIVER THIESSEN ANNE HICKMAN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Health a ALICIA THIESSEN WIFE 8321 HILLENDALE ROAD BALTIMORE, MD If hem 27 altimore 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Pages 1 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9/1/99 NEW CATHEDRAL CEMETERY BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Nema and Address of Fecility THE JOHNSON FUNERAL HOME, P.A. 21286 Approximete Intervat Between Onset and Death 8521 LOCH RAVEN BLVD. TOWSON, MD there the disease, or complications that caused the death. Do not shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel HEPATIC FAILURG ONE WELK disease or condition resulting in death) Examiner Examiner CIRRHOSIS physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inhibited events resulting in deeth) Last CANCER 2 MONTH Box 68760, Physician/Medical USB 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other stantificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes SENO 3 Probably 4 Unknown signed t Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 1 | Yes 2 | 1 | 10 1 ☐ Yes 2 ☐ No of Vital 25. Was casa rafarred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1 Yes 25 No this 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation Division or Attanding Naturel 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 24 hours after of Funeral Direct 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifie (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 1018220 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) ORK RD#203 BALTIMONG, MAZIZOLY

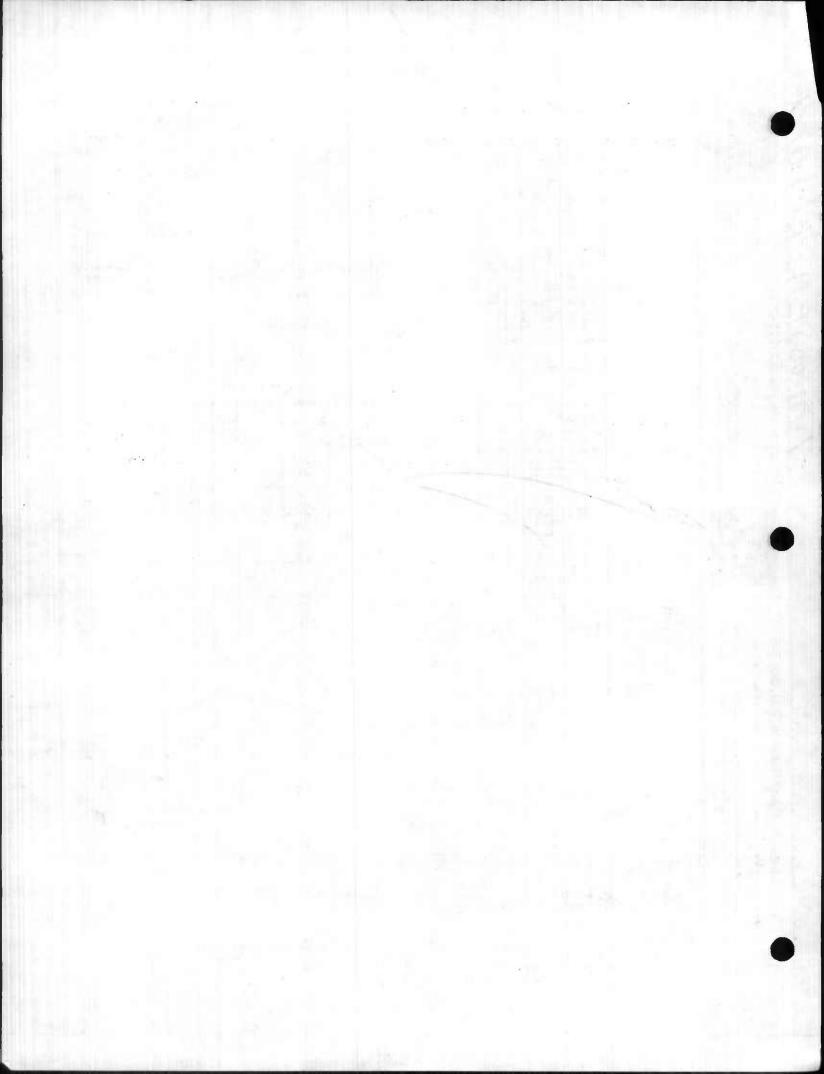
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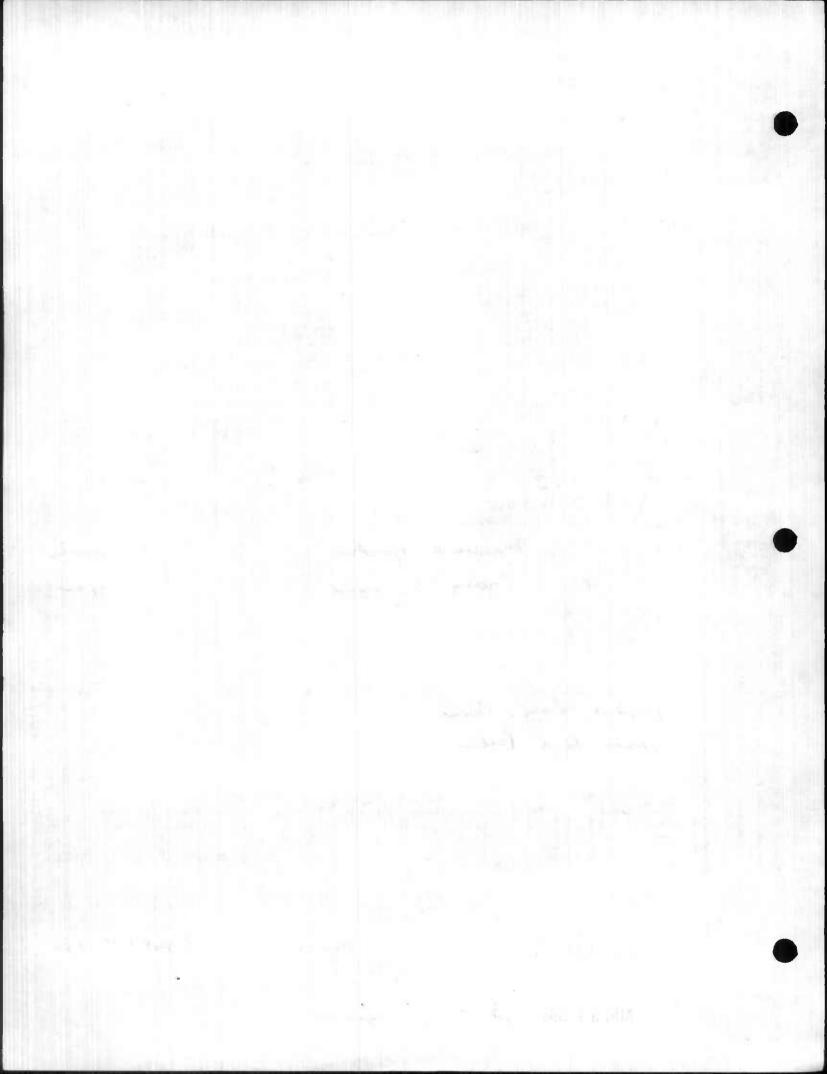
32. Registrer's Signature



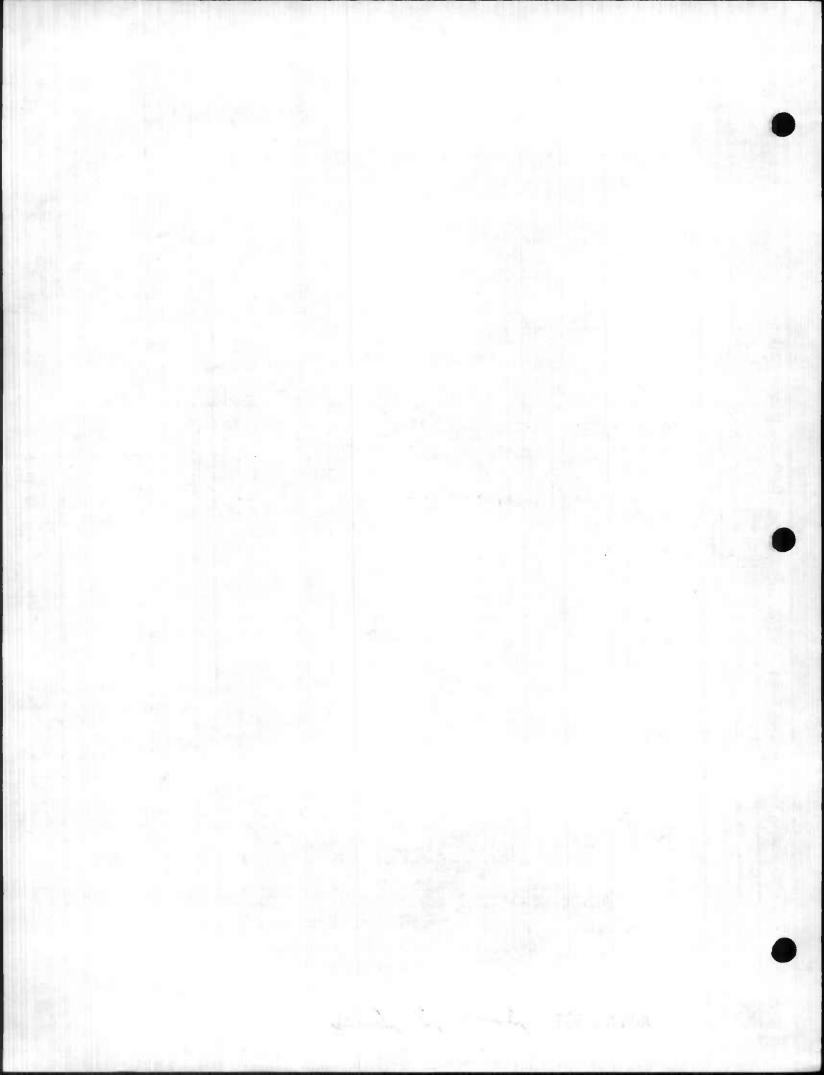
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Monroe Wright 1999 August 30 11:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Villa Nursing Home Baltimore Catonsville H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F Yrs. Director 78 Sept. 22,1920 Maryland 213-16-4351 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1⊠ Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. Nerna 23a 21223 2641 Lehman Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hyglens. Important: if item 27 is marked other than "natu any injury or other traumatic avent, the Medical 2008. 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Painter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frederick Wright Daisey Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Pine Heights Ave. Baltimore, Maryland 21229 Joseph A. Serio 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19-1-1999 Baltimore, Maryland Loudon Park Cemetery 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses Thomas 4107 Wilkens Ave. Baltimore, Maryland 21229 uanta Parts. Ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, an earl teilure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Finat disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be associted physician and s the buriel-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as e consequence of): 98 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Visula- Pascaje yd bengis 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No Division of Vital 25. Was casa referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Thursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 (Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the causa(s) and manner stated. Medical 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier august 31 " 1889 Clases Alla-CHARLES R. GRAHAM 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 1001 31. Date filed (Month, Day, Year) State AUG 3 1 1999 Registrar



	State of Maryland / Department of Health and Certificate of Death		g. No. 99	27358								
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Funeral	5. Sociel Security Number 6. Sex 7. Age (in yrs. lest birthdey) If Under 1 Year If Under 24 Hrs	8. Dete of Birth		9. Birthplace (State or Foreign Country)								
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6 8 6		10	g. Citizen of Wh									
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Depa Depa Impo	21. Signejurator Funerel Service Licentifies 22. Name and Address of Facility HUBBARD Funeral H	ome Balt	imore.	s Avenue MD 21229								
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Attending or death.	2 Accident Investigation	2/4										
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		a, end due to the ca urred at the time, da	use(s) and men ite and place, ar	ner as stated. Indicate due to the cause(s)								
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	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)											
	The state of the s	~ Place	Relt	wp 21217								
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ricgistia	AUG 3 1 1999 Deture B. Marsh											

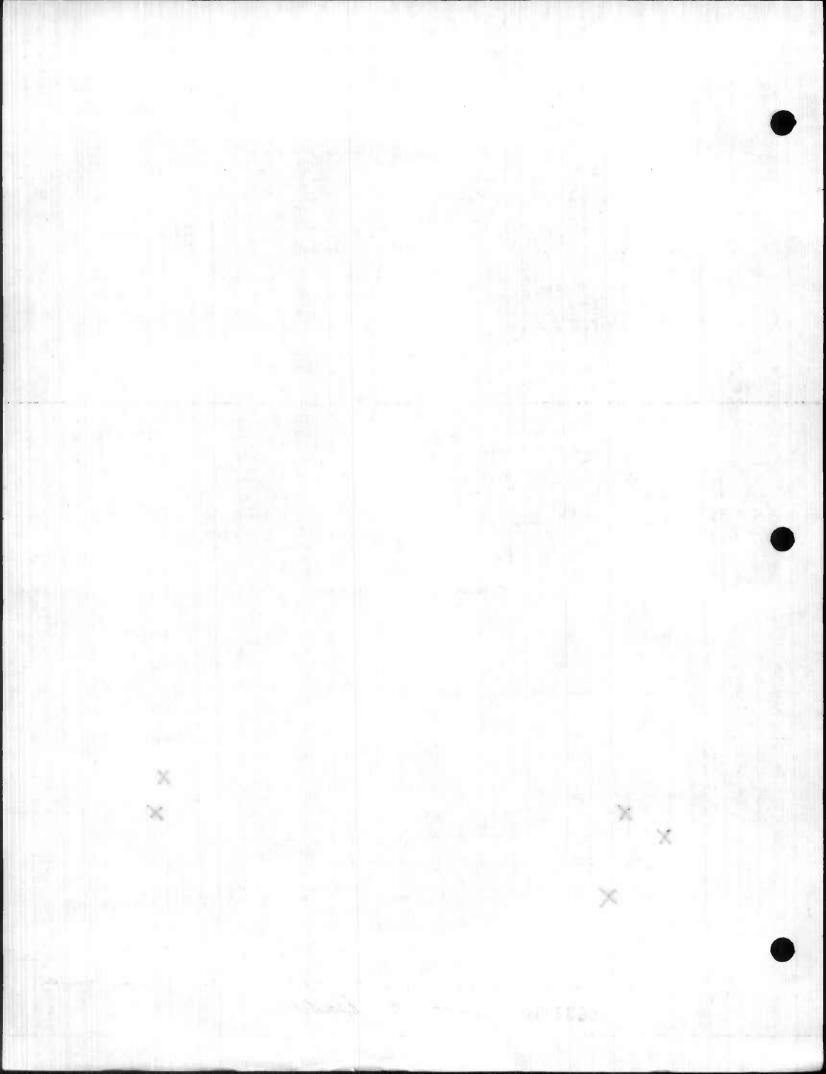


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1999 28, Lisette Andree Wagner AUG 11:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Arundel Anne 8. Data of Birth (Month, Day, Year) NOV 13, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2√2 F Months Days Hours Min. 067-36-1124 Yrs. 1943 Switzerland Director Usual Residence of Decedent 10a State 10h Cough 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Anne Arundel Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 610 Luther Street 21225 "natural", or flams 23s. USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White þ 3 □XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Hygiene. filled within Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 1 and 2 should be fill Health and Mental H tem 27 is marked off 86 Arthur Barbezat Charlotte Dellenbach 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health an Important: If Item 27 is a any Injury or an Jeffrey W. Wagner/son 610 Luther Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 08/30/99 4 Donation S Other (Specify) Baltimore, MD 21. Signature of Lunioral Service License 22 Name and Address of Facility Cremation Society of Maryland, Inc. A Edward 299 Frederick Rd. Baltimore, MD 21228 Gregorchik 23a. Part1. Entar the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Preumonia week Examiner Due to (or es a consequence of): Physician/Medical Examiner Metastatio lung concer 5 months physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 PYea 2 No 3 Probably 4 Unknown Division of Vitai Records, þ The law requires 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 A Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: 28b. Time of 28c. Injury at Work? After or Attending 5 Pending investigation 1 Yes 2 No death. Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) in 24 hours. the Funeral Director of the filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier DZ3809 8/30/99 dustin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rear Ctor. 22 S. Greene St., Baltimore, MD 21201 Doyle Greeneloum M.D. 31. Data tiled (Month, Day, Year) 32. Registrar's Signature State oaks AUG 3 1 1999 Registrar



Funeral Director

Be Completed by

10

Examiner

Physician /Medical

Examiner

Funeral

Director

Plea	se Type or								_	ble.			
	State of	of Marylan		artment ertificate			nd M	Mental Hygi	iene _{eg. No.} 9 9		7360		
Decedent's Neme (First, Middle First, Middle	e, Lasi) Blanche	T. Wil	Lson					2. Date of Death Month August	Dey	Year 999	3. Tima of Death 8:20 am		
4e Facility Neme (If not institution Stella Maris						4b. City, Town		ocation of Death	4c. County Bal	y of Death Ltimo	re		
5. Social Security Number 216-14-0073	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 89	. last birthday) Yrs.	Months (Vear Deys		24 Hrs. Min.	8. Date of Birth (Month, Day, APR 29,	Year)	9. Birthp Court Penr	9. Birthplace (State or Foreign Country) Pennsylvania		
Usuel Residence of Decedent 10a. Stete 10b. County MD Balti	10a. Stete 10b. County 10c. City, Town or Location									1	10d. Inside City Limits 1 Yas 2 No		
								0g. Citizen of V USA		try?			
11. Meritel Stetus 1 Never Merried 2 Marri 3 Widowed 4 Divorced	12. Wes Dec Armed Fo	cedent Ever in U, Forces? 2 X No Give		Was Deceder If Yes, specify			in? (Spe Puerto	ecity Yes or No- Rican, etc.)		ce - America eck, White, of fy: Wh			
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examiner?	Hospital:	Inpatient 2] ER/Outpatien	nt 3 DOA	Of	there are		ome 5 Resider		- ISnaci	4.1		
27. Menner of Death **Divident S Pending investig	g 28a. Dete (Mon	of Injury onth, Dey Year)	28b. Time of tnjury		c. tnju		1	28d. Describe how			"		
3 Suicide 6 Could n	ant he	ce of Injury - At ho ding, etc. (Specifi	iome, farm, str	reet, fectory,	office			28f. Location (Stre City or Town,	Il Route Number,				

To the Hospital or Attending Physician: The law requires thet the death cartificate be executed within 24 hours after death.

To the Fameral Director: After this cartificate has been signed by the attending physician and complicate in by the funeral director, page 2 should be detached for use as the burial-transit by Physician/Medicai Medical Certification: To Be Completed

Physician

/Medical Examiner

29e. Certifier (Check only one)

fying Phyalcian: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner as stated.

cat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner steted. 29c. License number

29b. Signatu

D 15504

29d. Date signed (Month, Day, Year) F-30

Timonium, Md 21093

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

2300 Dylaney Nakhuda, $M \cdot D$ Eddie

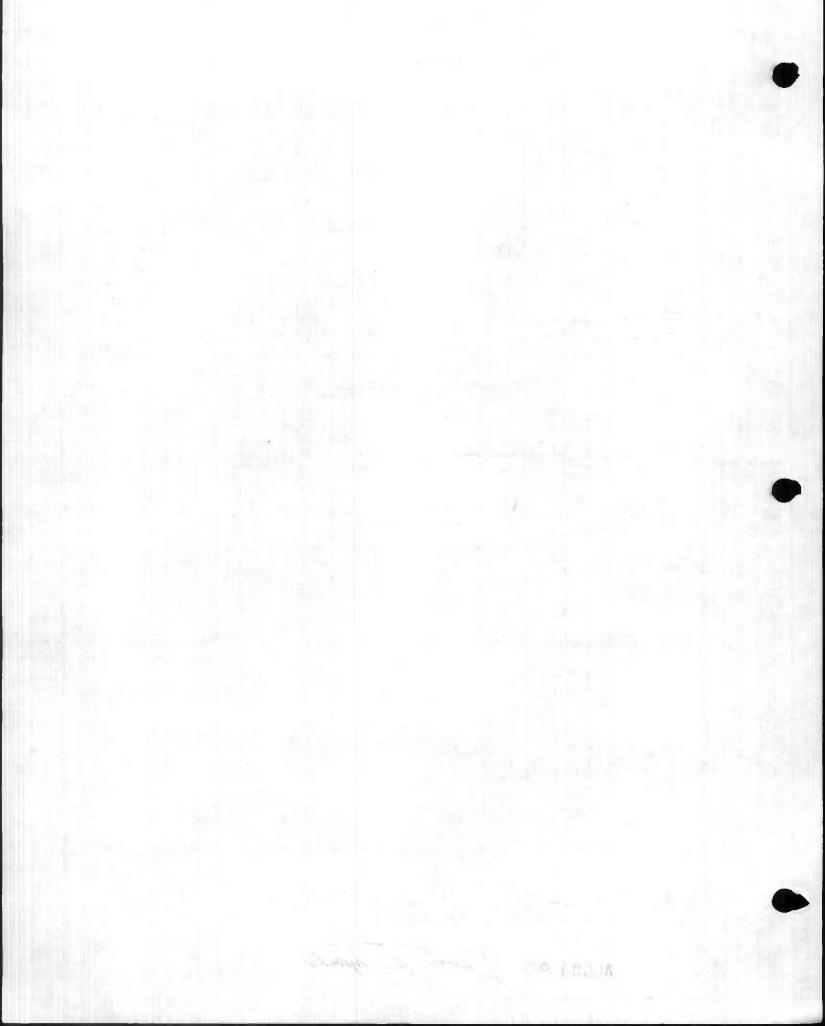
31. Dete filed (MAUG3Yar)1999

Valley Rd 32. Registra en Signeture

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland / Department of Health and Certificate of Death	Mental Hygiene Reg. No.	99 27361
Physician /Medica	Frank A. Wrzosek		Year 3. Time of Death 999 11:30 pm ounty of Death
Examine Funeral Director	Manor Care-Rossville Rosedale 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 215-12-8693 1XI M 2□ F 77 Yrs. Months Days Hours Min	Bal	9. Birthplaca (Stata or Foreign
Maryland Fathow Sed.at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore Baltimore		10d. Inside City Limits 1 ☐ Yas 2 ☑ No
oath with the Maryla ns 23a or 28a-f shor mast be notified at	10e. Street and Number 10f. Zip Code	10g. Citize	on of What Country? U.S.A.
The Control			. Race - American Indian, Black, White, atc. pecify: White
21215-0020 ed within 72 hours at yglens. yglens restural; or rt. the Medical Exam.		Balt	of Business/Industry imore City rument
Maryland and Assume the standard to the standard other traumetic event,	17. Father's Neme (First, Middle, Last)	ome (First, Middle, Meiden St Cwalinska	umeme)
- 5875	19a. Informant's Name/Relationship (Type, Print) Mrs. Bernadine Wrzosek (wife) 19b. Mailing Address (Street and Number or R 4 Juliet Lane, Unit	#102, Baltimo	re, MD 21236
Baltimore emit. Pages 1. Appartment of Ha my injury or oth tics.			ition - City or Town, State
Bal Perm Depa Impo	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funera 9705 Belair Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	Baltimore, M	D 21236
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. End Stage Cardio Myo Paragraphic in the condition resulting in death) Due to (or as a consequence of):	F 30.4 31.04	Interval Between Onsat and Death
. BOX 68/60, death certificate be executed e attending physician and id for use as the burial-transit	Cause (Diseasa or Injury that initiated events Due to (or as a consequence of):		
O # # #	Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.	23b. Did tobacco us	se contribute to the cause of death? No 3 Probably 4 Unknown
COTGS, w requires th s been signed 2 should be d		24e. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
= F # a 2	25. Was case referred to medical 25. Place of De	1 ☐ Yes 2 Æ	Ño 1□Yes 2□No
OIVISION OF or Attending Physical death. Director: After this in by the funeral di	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Wursing I	Home 5 Residence 6 28d. Describe how injury of 28f. Location (Street and City or Town, Stete)	
he Hospital in 24 hours : he Funeral pletely filled	29e. Certifier (Check only one) 29m Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred and manner stated.	e, and dua to the cause(s) ar urred et the time, date and p	nd manner as stated. lace, and due to the cause(s)
To the To the Comp	29b. Signature and title of official 29c. License number D4547s	GI	signed (Month, Day, Year)
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mohammad Rahnama, 17 Fontana Lane, Baltimore, M 31. Date filed (Month, Day, Year) 32. Requirter's Signature	D 21237	
State Registrar	31. Date filed (Month, Day, Year) AUG 3 1 1999 32. Restrictes Signature 4. Spacks		



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sician	1. Decedent's Name (First, Middle, La	ist)		Death 2. Date of	Reg. No.	3. Time of Death
	RUTH	Α.	WILLIAMS	AUGUS	Day Year	08:30 PM
ledical iminer	4a Facility Name (If not institution, given		WILLIITAMS	4b. City, Town, or Location of I		
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eral tor	0 1 0 1 1/7	Sex 7. Age (In yrs. le	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Month	n, Day, Year) C	thplace (Stete or Foreign ountry) ARYLAND
4	10a. State 10b. County	10c. City	, Town or Location			10d. Inside City Limits
uneral Director	MARYLAND N/	A	BALTIMORE			1 ☐ Yes 2 ☐ No
Director	10e. Street and Number	`	10f. Zip Code		10g. Citizen of What C	ountry?
- E	2105 E. PRESTO		2121		U.S.A.	
by Funeral	11. Marital Status 1 Never Married 2 Merried	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes o pan, Mexican, Puerto Rican, etc Specify:		
D D	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates:	16a. Decedent's Usual Occu		16b. Kind of Business	
Completed	(Specify only highest gra	ade completed)	(Give kind of work done life. DO NOT use retire	during most of working	Too. Kind of Business	Minocolly
ф	Elementary/Secondary (0-12) N/A	College (1-4or 5+) 2YEARS	MEDICAL TERM	MOLOGIST	SOCIAL SE	CURTTY
Be C	17. Fether's Name (First, Middle, Last			18. Mother's Name (First, Mi		
0	ANDREW WILLI	AMS		MARGARE'	r WHITTINGS	
To Be C	19a. Informant's Name/Relationship ((Type, Print)	19b. Mailing Address (Stree	t and Number or Rural Route N	umber, City or Town, State,	Zip Code)
	AUDREY HUGGINS 20a. Method of Disposition	/ DAUGHTER	2105 E. PRI	ESTON ST. BA	LTO MD 2	1213
5	1 Burial 2 ☐ Cremetion 3 ☐	Removal from Stete	metery, crematory or other pla	PARK		
	4 Donation 5 Other (Special 21. Signeture of Funeral Service Lice	**	22. Neme and Addr		3, 1999BALT	O,MD.
Suc	Lit is solved by the solved bloom	+.		S. SCRUGGS F	UNERAL HOME	
	23a Part 1 Enter the disease or com	Unlications that caused the death	1412 E.	PRESTON STR	EET BALTO,	MD. 21213
ian	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line.	bo not enter the mode of dy	ing, sour as cardiac or respiren	ny ariost,	Interval Between Onset and Deeth
ian cal	Immediate Cause (Final	Myocan	dist Tal	failure		/ hours
er	disease or condition resulting in death)	a	as a consequence of):	00.01007		1 1000
<u>=</u>	_	meest	ne Heent	failure		years
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):	1		-
Cal	Cause (Disease or injury	C		E I		
_	that initiated events resulting in death) Last	Due to (or	as a consequence of):			
N.		d				
	Part II. Other significant conditions of	contributing to death but not requi	ting in the underlying cause of	iven in Pert I 22h	Did tobacco use contribut	a to the cause of death?
Clar	wares any market continuous		and and and any and any and any	230.		Probably 4 Unknown
hysician	Hineson	115/1920				toomer! all ourseum
by Physician/Med	Hyperle	usion				, 2000
þ	Hyperle	uslon		248.	Was an autopsy performed?	Were eutopsy findings available prior to completion of cause of death?
b	Hyperle	uslon				Were eutopsy findings available prior to completion of cause
Completed by	25. Was case referred to medical	uslon			performed? 1□ Yes 2□No	Were eutopsy findings available prior to completion of cause of death?
b	25. Was case referred to medical axaminer? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	Proutpatient 3LI DOA	26. Place of Death (Check of ther:	performed? 1□ Yes 2□No	Were eutopsy findings available prior to completion of cause of death? 1 Yes
To Be Completed by	25. Was case referred to medical axagniner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of trijury (Month, Day Year)	28b. Time of Injury 28c. Injury	26. Place of Death (Check of them: 4 Nursing Home 5 upy at 28d. Description)	1 Yes 2 Like	Were eutopsy findings available prior to completion of cause of death? 1 Yes
To Be Completed by	25. Was case referred to medical axagniner? 1 Yes 2 No 2. Manner of Death Natural 5 Pending investigation	Hospital: 1 Inpatient PSE 28a. Date of trijury (Month, Day Year)	28b. Time of Injury M 1	26. Place of Death (Check of ther: 4 Nursing Home 5 up at 28d. Description) Yes 2 No	performed? 1 Yes 2 No only one) Residence 6 Other (Sp ribe how injury occurred	Were eutopsy findings available prior to completion of cause of death? 1 Yes ANO
To Be Completed by	25. Was case referred to medical axigniner? 10 75 2 No 27. Manger of Death	Hospital: 1 Inpatient PSE 28e. Date of trijury (Month, Day Year)	28b. Time of Injury M 28c. Injury M 10	26. Place of Death (Check of ther: 4 Nursing Home 5 pry at 28d. Descript?) Yes 2 No 28f. Locat	performed? 1 Yes 2 La No only one) Residence 6 Other (Sp	Were eutopsy findings available prior to completion of cause of death? 1 Yes ANO
Certification: To Be Completed by	25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28e. Date of trijury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify)	28b. Time of Injury M 15 M 15 M 16 M 16 M 16 M 16 M 16 M 16	26. Place of Death (Check of them: 4 Nursing Home 5 28d. Descript? Yes 2 No 28f. Locat City of them	performed? 1 Yes 2 Mag only one) Residence 6 Other (Sp ribe how injury occurred ion (Street and Number or F or Town, Stete)	Were eutopsy findings available prior to completion of cause of death? 1 Yes AND
Certification: To Be Completed by	25. Was case referred to medical axaminer? 1	Hospital: 1 Inpatient 28e. Date of thiury (Month, Day Year)	28b. Time of Injury M 15c. Injury M 15c. Injury M 16c. Inj	26. Place of Death (Check of ther: 4 Nursing Home 5 and the south of	performed? 1 Yes 2 TANQ only one) Residence 6 Other (Sp ribe how injury occurred ion (Street and Number or F or Town, Stete)	Were eutopsy findings available prior to completion of cause of death? 1 Yes No Pairal Route Number,
To Be Completed by	25. Was case referred to medical axagniner? 1	Hospital: 1 Inpetient 28a. Date of thjury (Month, Day Year) 28a. Place of Injury - At horbuilding, etc. (Specify) hysician: To the basis of examination	Description of Injury Market States of Injury Market States on and/or investigation, in my 29c. Licen	26. Place of Death (Check of them: A	performed? 1 Yes 2 TANQ only one) Residence 6 Other (Sp ribe how injury occurred ion (Street and Number or F or Town, Stete)	Were eutopsy findings available prior to completion of cause of death? 1 Yes ANO Parity) Fural Route Number, Is stated. e to the cause(s)
edical Certification: To Be Completed by	25. Was case referred to medical axigniner? 10 75 2 No 27. Manner of Death P Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Carrillar 15 Certifying Photost anny 2 Madical Examples	Hospital: 1 Inpatient 28e. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify) nysician: To the basis of examination	Produpation 3LD DOA 28b. Time of Injury M 28c. Injury M 10 ne, ferm, street, factory, office fedge, death occurred at the ton and/or investigation, in my 29c. Licen	26. Place of Death (Check of them.) 26. Place of Death (Check of them.) 28d. Description (Check of them.) 28d. Descrip	performed? 1 Yes 2 No only one) Residence 6 Other (So ribe how injury occurred on (Street and Number or For Town, Stete) of the cause(s) and menner a ime, date end place, and du 29d. Date signed (Mor	Were eutopsy findings available prior to completion of cause of death? 1 Yes ANO Parity) Fural Route Number, Is stated. e to the cause(s)
edical Certification: To Be Completed by	25. Was case referred to medical axaminer? 1	Hospital: 1 Inpatient 28e. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify) nysician: To the basis of examination	Produpation 3LD DOA 28b. Time of Injury M 28c. Injury M 10 ne, ferm, street, factory, office fedge, death occurred at the ton and/or investigation, in my 29c. Licen	26. Place of Death (Check of them: 4 Nursing Home 5 ary at 28d. Description 28d. Locat Cdy of time, date and place, and due to opinion, death occurred at the file.	performed? 1 Yes 2 No only one) Residence 6 Other (So ribe how injury occurred on (Street and Number or For Town, Stete) of the cause(s) and menner a ime, date end place, and du 29d. Date signed (Mor	Were eutopsy findings available prior to completion of cause of death? 1 Yes ANO Parity) Fural Route Number, Is stated. e to the cause(s)

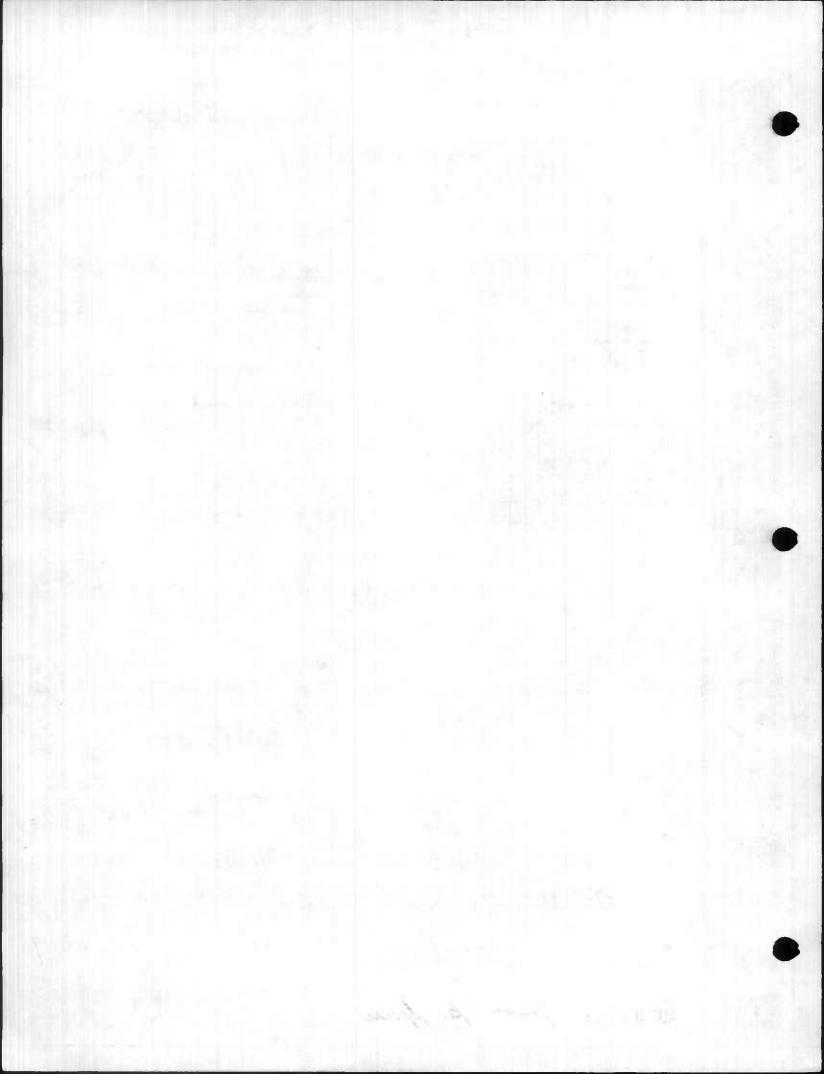
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** 8:14 am WILLIAMS **EDWARD** 1999 AUG /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ROCK GLEN NURSING CENTER If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (S Country) MARCH 26 1902 unknown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 97 Yrs 214-20-7397 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d, inside City Limits 1XXVes 2 □ No Director MARYLAND N/A BALTIMORE 28a-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 3407 EDMONDSON **AVENUE** 21229 U.S.A. Funeral Wes Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after vincil of leafing and Mental Hyplaces, exit; if fleen 27 is restited other than "naturals, or the ury or other traumetic event, the Medical Examines ury or other traumetic event, the Medical Examines 1 ☐ Yes 2 XX90 If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 Yes 2KNo Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOTEL BELVEDERE HOTEL unknown 18. Moiher's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) unknown unknown 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Norma Williams/Daughter 3407 Edmondson Avenue, Baltimore, Maryland 21229 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 XX urlel 2 Cremetion 3 Removel from State ARBUTUS MEMORIAL PARK 9-2-99 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name end Address of Fecility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA nown 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onsei and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) rdiac Arry hmig
Dua to (or as a consequence of):
Les Clesotic Cardw vas was Piscae /Medical Examiner Physician/Medicai Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or Injury that initieted events resulting in deeth) Last The law requires that the death certificate be execu Box 68760, Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Be Completed 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case raferred to medical exeminer? 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. injury at Work? 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Naturel 2 Accident 5 Pending s after death. 1 Yes 2 No investigation 3 Sulcide 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edical completely To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) Farnesh sabapally 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture AUG 3 1 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day LOUISE LUCILLE MINOR WILLIS August 28, 1999 2:45 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Edenwald Health Care Center Towson Baltimore If Under 1 Yeer if Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) Deys Months 1□M 2♥F Yrs 215-30-2071 Nov. 13, 1904 Md. Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₺ No Md. Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Rd. 21286 USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2√ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk 12 State of Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) В. Minor Aubrey Annie Krebs 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 113 Nob Hill Park Dr. Reisterstown, MD. 21133 Kitty Douglas/friend 20e. Method of Disposition Dete 20c. Location - City or Town, Stete

Physician /Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Medical Examiner insult be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 early injury or other traumation.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner

Physician/Medicai þ Completed Be Certification: To

Medical

25. Wes case referred to medical

29b. Signature and title of ceryfield

31. Dete filed (Month, Day, Year)

5 Pending

investigation

AUG 3 1 1999

6 Could not be

1 ☐ Yes 2 ☐ No

27. Manner of Denth

2 Accident 3 Suicide

4 D Homicide

29s. Certifier

1 Swetural

1 XBurial 2 Cremetion 4 Donetion 5 Other (S		,	Park Cemetery	8/31/99	Baltimore,	Md.
21. Signature of Funeral Service	De Barre	7)	22 Name end Address of F Ruck Towson 1050 York Rd.	Funeral Home Towson, MD.	, Inc. 21204	
23a. Pert1. Enter the disease, or shock, or heert feilure. List	complications that caused to only one cause on each line	the deeth. Do n	ot enter the mode of dying, such	h es cardiec or respiretory e	orrest,	Approximate Intervel Between Onset end Death
Immediate Ceuse (Final disease or condition resulting in death)		(twhe			1 w/c
	- 1	Oue to (ordes a o	intigal S	Luke		3705
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	C	oue to (or es e c	onsequerice of):	eventra		5 yes
thet initiated events resulting in deeth) Lest	d	Bip	onsequence of):	der		303-
						/ /

Pert II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

28e. Date of Injury (Month, Dev Year)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 23e) (Type, Print)

physician at the burial Box 68760, Records, P.O. the signed by Division of Vital To the Hospital or Attending Physician: After within 24 hours after death.

To the Funerel Director: A completely filled in by the ft death.

State

Registrar

28c. Injury et Work?

Medical Exeminar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

Critifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

1 ☐ Yes 2 ☐ No

23b. Did tobacco use contribate to the cause of death?

3 Probably 4 Unknown

24b. Were eutopsy findings aveileble prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yas 2 No

2 - No

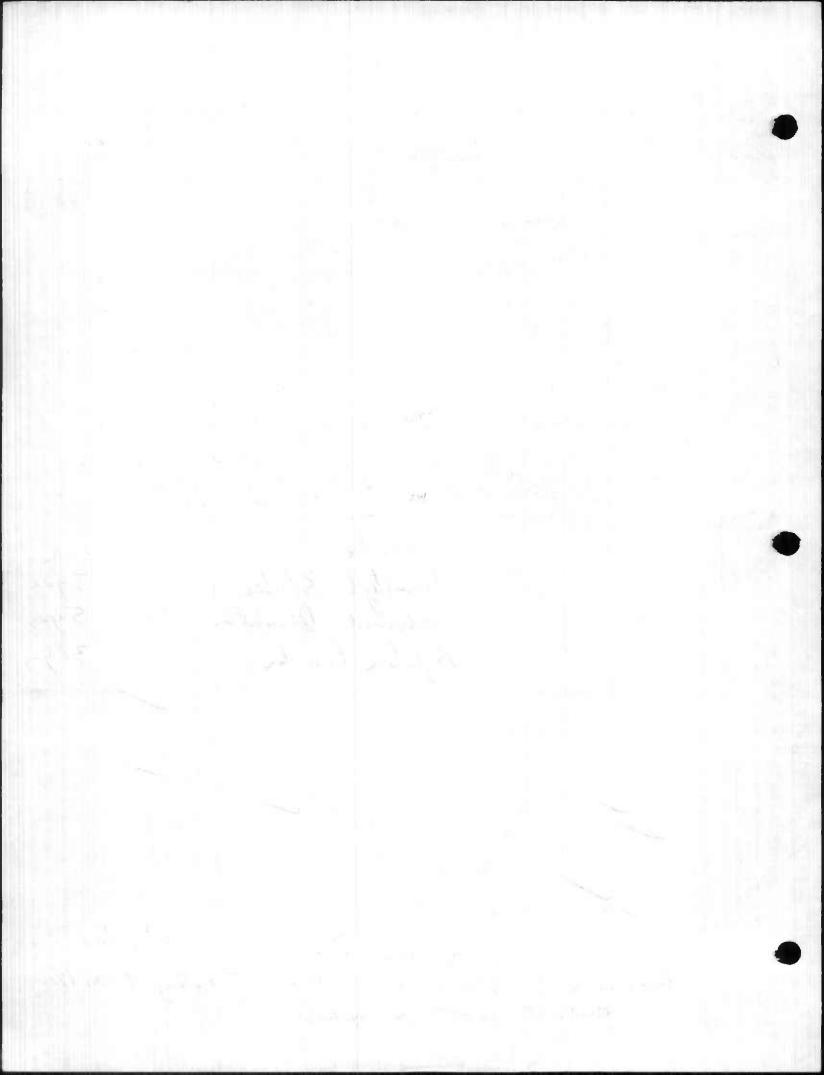
24e. Wes an autopsy performed?

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28. Plece of Death (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

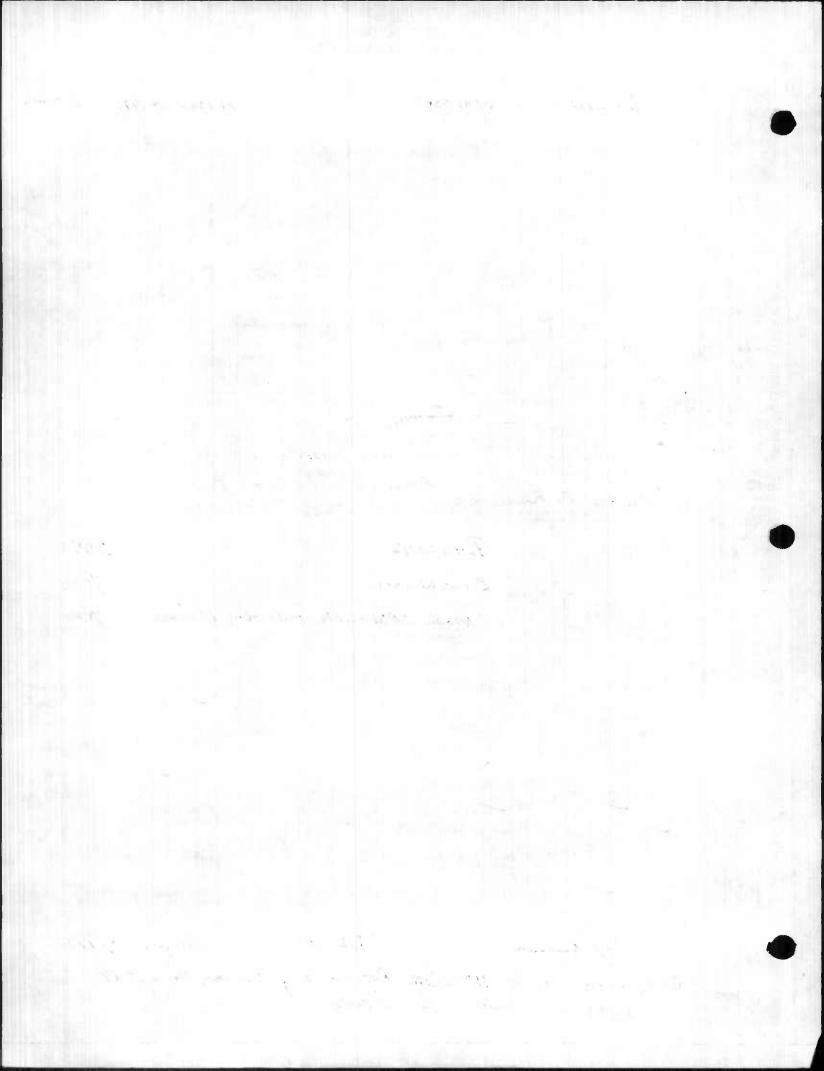


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• •			
State of Maryland / D	epartment of Healt	th and Mental Hygiene	
			130

Certificate of Death Reg. No 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death August 28 1999 **Physician** BEATICE C 1:00 Am. WATSON /Medical 4a Fscility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yes 217-36-2942 80 Director MD. May 17, 1919 Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limita MD. Howard Columbia 1 X Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? b 5400 Vantage Point Road 21044 23a U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important if Item 27 is marked other than "netural", or lis any injury or other traumatic event, the Medical Examine. 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: white þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) real estate agent real estate 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meidan Surnama) Be Walter G. Crook Pentz Agnes 10 19e. Informant'a Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Susan Watson, daughter 12023 Yellow Bell Lane, Columbia, Md. 21044 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Bunal 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore/Washington Crem. 8/31/99 Laurel, Md. 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 21045 Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final tweendovia diseasa or condition rasulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner BronchieTHIS sician end burial-transit Hospital or Attending Physician: The law requires that the death certificata be executed Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last Due to (or as a consequence of): CIMONIC OBSTRICTIVE Relmoney D. Seese P.O. Box 68760, \$ Due to (or as a consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by ate has been signe page 2 should be Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate 25. Was case referred to medical examinar? director, 8 26. Place of Deeth (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred After 1 Natural 5 Pending investigation death. 1 Yas 2 No 2 Accident after death filled in by the 6 Could not be detarmined 3 Suicide 28a. Place of fnjury - At homa, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mennar ateted. 29a Certifiar (Check only one) ŝ 29b. Signatura and title of con-29d. Date signed (Month, Day, Year) 29c. License number August 28, 1999 D22356 Mema and addrass of person who completed cause of death (Item 23a) (Type, Print)

RERY I, hever, No. 11055 L: The Paruxet Pky, Colcumbia, Md 21044 32. Registrar'a Signature 31. Data filed (Month, Day, Year) State AUG 3 1 1999 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deethpin epdent'a Name (First, Middle, Last) 2. Dete of Death Day **Physician** enjamin 29 99 08 /Medical 4e Facility Name III not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON EDENWALD BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 06/23/1905 9. Birthplace (State or Foreign **Funeral** Months Days 15€M 2□ F Hours VIRGINIA 213-10-4081 94 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD BALTIMORE 28a-4 TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 800 SOUTHERLY RD. 21286 23a USA Funeral Nema 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 21215-0020 8 1 Yes 2 KNo Specify: Specify: Ž, 3≅ Widowed 4 □ Divorced WHITE 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) 4yrs INDUSTRIAL ENGINEER ENGINEERING Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be fall mant of Health and Mental H lant: if Nem 27 is marked off Be BENJAMIN H. WEST ANN PAGE WALKER 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JOHN S. WEST (SON) 3832 PAMAY DR. MCHANICSBURG, PA. 17055. altimore, 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State b Department of Important: If 4 ☐ Donetion 5 ☐ Other (Specify) HOLLYWOOD CEMETERY 09/03/99 RICHMOND, VA. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO 4905 YORK RD. BALTO., MD. 2 Wean 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart leiture. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finet VVYGO disease or condition resulting in death) Examiner equence of). Examiner the death certificate be axecuted the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated successor injury) Due to (or es a consequence of): physician Physician/Medicai that initieted events resulting in death) Last Due to (or es a consequence of) US0 85 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that Completed by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 1 Yes certificate 2111 1 ☐ Yes 2 ☐ No Physician: director. 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ jo this funeral 28a. Date of Injury (Month, Day Year) 27. Manner 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation Division Attending **Civatural** ours after deal.

Vi Director: Ah.

in by the fire 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28I. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide 24 hours 29a. Certifier Medicai 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. miner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner steted. (Check only one) To the Vithin 2 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 8 d cause of ceath (Item 23a) (Type, Print) 30. Name and address of person who MARCELINO D. ALBUERINE 1120 N. ROLLING RD. CATONSVILLE, MD. M.D. 21228.

State Registrar 31. Date filed (Month, Day, Year)
AUG 3 1 1999

32. Registrar a Signature

" Sporks

Transporter A March water to find

death certificate be axecuted Box 68760, P.O. Division of Vital Records, Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this carific 24 hours To the P within 2.

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with the Maryland

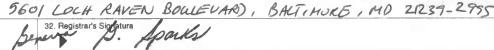
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Baltimore, Maryland 21215-0020

State Registrar

RAMIN ACTAHA. 31. Data filad (Month, Day, Yaar) AUG 3 1 1999 AUG 3

29b. Signetura end title of certifier



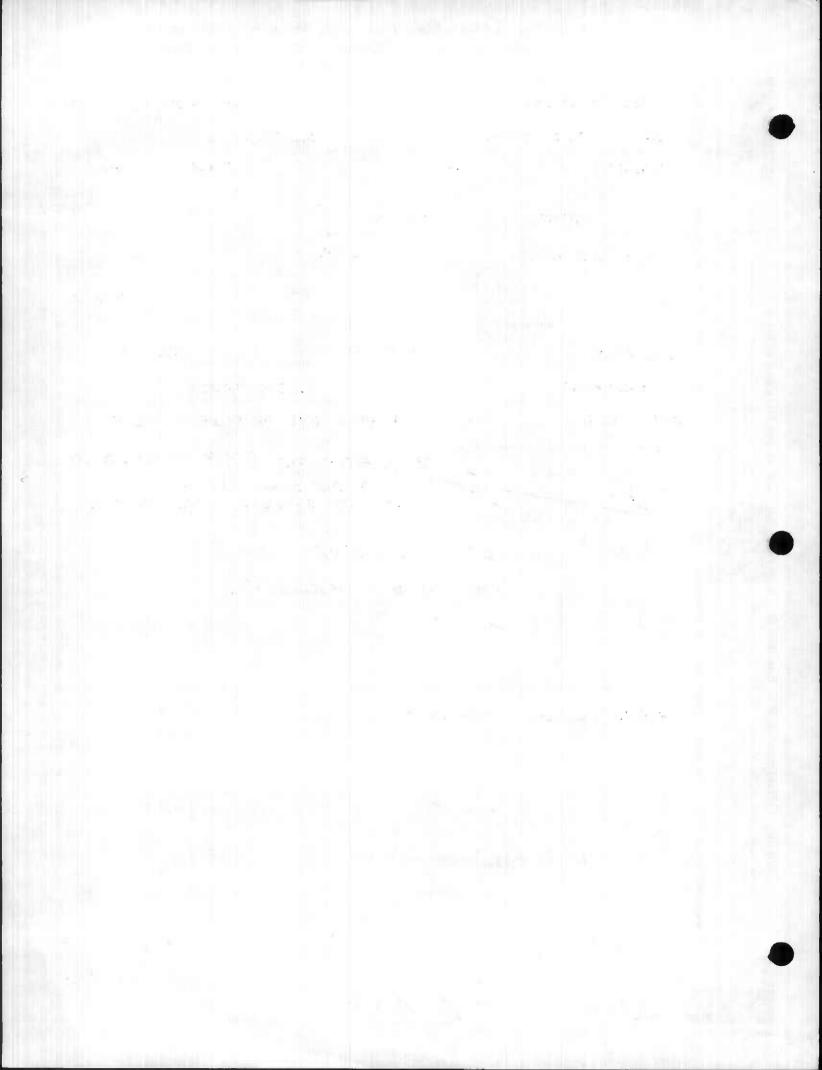
30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

sacks

29c. License number

29d. Dete signed (Month, Day, Year)

08,28,1999



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		State o	f Maryla		partmer <i>ertifica</i> :		lealth and Death		giene 🎾 . Reg. No.		6.14	100
1. Decedent's Nan	ne (First, Middle, La	ist)						2. Dete of De Month		Yeer	3. Tim	a of Death
John R.	Wright S	ye street end nu	mher)				4b. City, Town, or	August	29, 19	99	6:00) pm
	k Manor.			k Rd.			Finksburg			rrol		
5. Sociel Security I 105-01-1	Number 6. 9	Sex 12 M 2□ F	7. Age (In yrs			Deys	If Under 24 Hrs	8. Dete of Bir	th Year) 907	9. Birth	nplece (Ste untry)	ete or Foreign
Usual Residence of 10a. Stata MD	10b. County Baltimo	ı tı o		ity, Town o	r Location							le City Limits
		re	K	essie								185 412,140
5 Clarks						p Code 1136			10g. Citizen of V	What Col	untry?	
	ried 2 Married	12. Was Dec Armed Fo 1 Tyes If Yes, Gir Yaar or D	2 X No ve	U,S.	13. Wes Dece If Yas, spe 1 Yes	ecity Cul	Hispenic Orlgin? (Span, Mexican, Puar Specify:	Specify Yas or No to Rican, etc.)	Blac	e - Amai ck, White v: Wh	2.111	n,
(Spe	15. Decedent's E	ducetion ede completed)	1.dor 5.)	16e. De (C	ecedent's Usi Give kind of w fe. DO NOT t	uel Occu ork done use retin	pation during most of wo ed)	rking	16b. Kind of Bi	usiness/l	ndustry	
Clamentery/Sec	ondery (0-12)	4 /.	1-401 5+)	Sa	les Re	pres	entative		Book So	ales		
	(First, Middle, Lasi nklin Wri							me (First, Middle Reddick		10)		
19a. Informent's N	Wright,	(Type, Print)	Son				et and Number or A				ip Code)	
	sposition Cramation 3 [5 Other (Speci		Ctata	cemetery,	isposition (Ne cremetory or een Me	other pl	al Gard.	Dete 9/2/1999	20c. Location -	wrg,	MD	a
21. Signature of F	B B	nsee EL					ess of Facility ral Home					<1
23a. Part1. Enter shock, or he	sease for con lure. List only			eth. Do not	enter the mo	de of dy	ing, such es cerdia	c or respiratory e	rrest,	1		dmete I Betwaen and Death
Immediate Ceuse disease or conditi resulting in deeth)	ion		Due to	(or as a cou	nsequence of).					dn	w
		b	ASC.	VD						1	10	14
Sequentially list of eny, leeding to it ceuse. Enter Und Ceuse (Disease of	mmediate lerlying or Injury	C	aly	rem	nsequence of): 				1	5	5
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Pert II. Othar elgn	ificant conditions	contributing to d	eeth but not re	sulting In the	ne underlying	ceuse g	iven in Pert I.		tobacco use co			uee of death?
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								10	Yes 2 TNo		1 🗌 Yes	2 No
25. Wes case refe	erred to medical						26. Plece of De	eth (Check only	-			
exeminer?	No	Hospital: 1	Inpatient 2	☐ ER/Outp	atient 3 C	OOA C	ther: 4 Nursing	Home 5 Res	idence 8 DOtt	ner (Spe	city)	
27. Menner of Dea	ath	28e. Date	of Injury	28b. Tin	ne of	28c. Inj	ury et	28d. Describe	how Injury occur	red		

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

25. Wes ca exemin 1 Ye 27. Menne 1 Naturel 2 Accident

Director

Funeral

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Completed

To Be

Physician/Medical Examiner

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edical Certification: To Be Completed

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any injury or o

Physician

/Medical **Examiner**

Physician /Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

permit mere of Health and Mental Phyliene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examine must be notified at

5 Pending invastigation 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

(Month, Dey Year)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifler (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as steted.

Medical Examiner: On the best of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

29b. Signaturg.am

August 30, 1999

30. Neme and

31. Det filled (Month,

driess of person who completed cause of deeth (Item 23e) (Type, Print)

488 Porty Road Westminter Tred 2/157

Onth, Pey Year) 99

12. Registrar's Signetury Sparks

State Registrar

"To let " Street of There's THE PERSON AND ADDRESS OF THE PARTY OF THE P

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #20B, 1 PER MEO G775 9-1-99 WR. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) RANDFORD ANDERSON 2. Date of Death 3. Time of Death 1999 **Physician** Anger San August 20:05 MANTORD 28 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins-Bayview Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Yrs. 54 215-40-9066 Director Sept. 25, 1944 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Md. Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3731 Lochearn Drive 21207 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 72 hours efter 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ified within 7. I Hygiene. Dundalk Comm. Elementary/Secondary (0-12) College (1-4or 5+) Director of Business & Industry College permit. Pages 1 and 2 should be flik Department of Heelth and Mental Hy Important: If Item 27 Is marked oth eny Injury or other treumatic event pates. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Anderson Carrie Lanier 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son Randford Anderson, Jr. 5620 Pioneer Drive Baltimore, Md. 21214 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition KING MEMORIA (Propries) 1 Rurial 2 Cremetion 3 Ruy 4 Donation 5 Other (Specify) noval from State Woodlawn Cemetery Sept. 3 Baltimore, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Lie 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that cardy of the Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat DILATED CARDIOMYOPATH disease or condition resulting in death) Examiner Physician/Medical Examiner g physician and es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Hypertension Records, þ 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 212 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 thpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours efter death. To the Funeral Director: After th completely filled in by the funera edical Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? After Division 1 D Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

Registrar

State

Wen-Israng

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Wen-Hsiang.
31. Date filed (Month, Day, Year)

Lee

32. Registrar's Signature

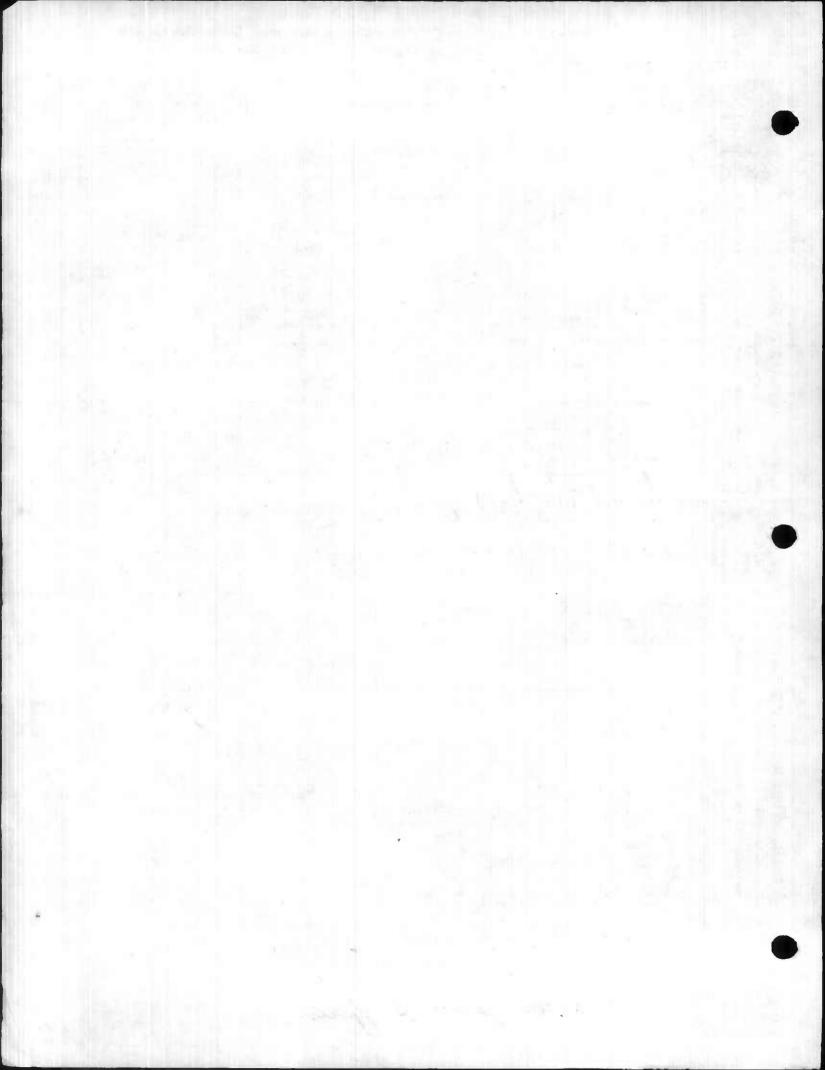
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

RES-000

Johns Hopkins Bayview Medical Center, 4940 Eastern Ave., Baltimore, MD

August 28, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ROBERTA BURD 5:00 pu A46459 /Medical 4a Fscility Name (If not institution, give street end number) 4b Gity, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Hospital orthwest andallstown If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country); 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2 F Montha Hours 214-18-1560 100 Va Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Ma Woodlawn Director 12a ltimore 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 4.5 21244 23a bridge 22 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried yland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Black by 3 Widowed 4 □ Divorced Completed the Medical 16b. Kind of Bualness/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government Pages 1 and 2 should be filled within vent of Health and Mental Hygiene. Int: if Item 27 is marked other than 1 Elementary/Şecondary (0-12) College (1-4or 5+) hab Technician Coth grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Olivia WOMBLE Hope 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/244 19s. Informant's Neme/Relationship (Type, Print) important: If Item 27 is m any injury or other traum once. Woodlawn, ud -Daughter Drive rances 3122 ambridge Baltimore, Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) Baltimore yd Baltimore National Cey -99 21 Signature of Funeral Service Licensee 23a. Party anter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, albeit, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examin physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Ö 1 Yes 2 No 3 Probably 4 Unknown Records, ð cardiae Au Cy Thuras 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Afferi or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not ba 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital edicai 29e. Certifier Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. (Check only one) To the V within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified W ess of person and completed cause of death (Item 23a) (Type, Print) 30. Name and add

State Registrar

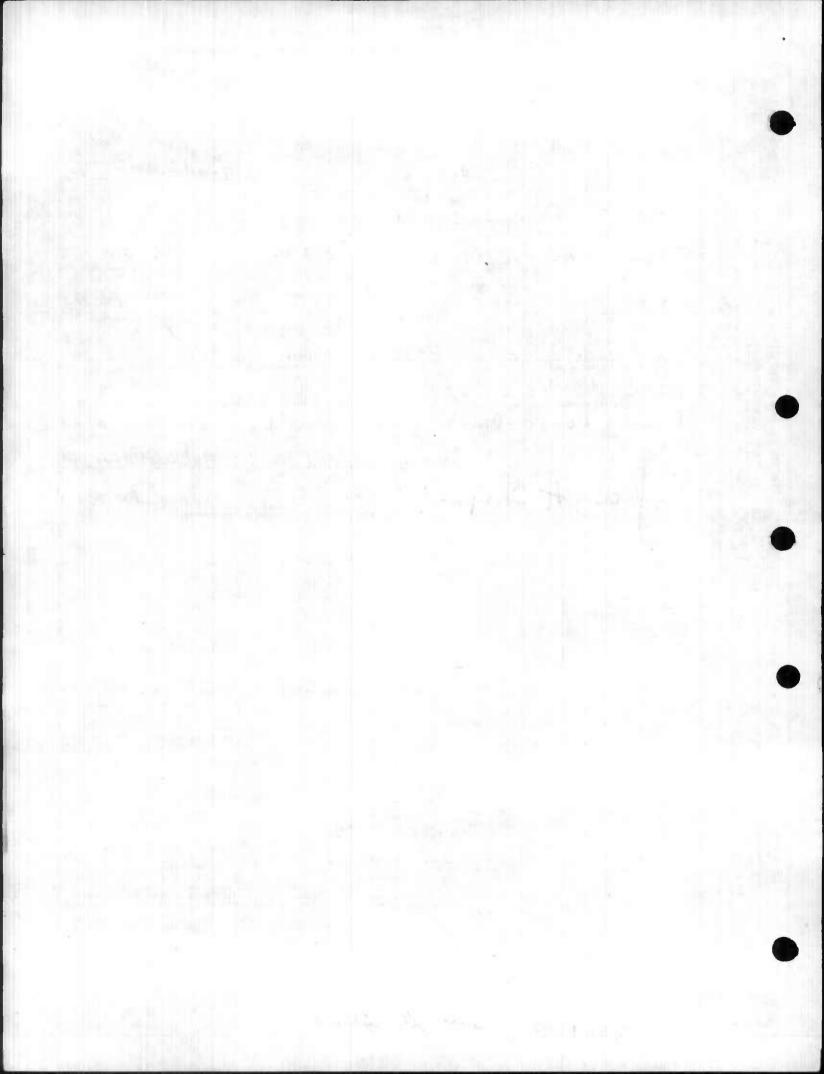
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31. Date filed (Month, Day, Year)

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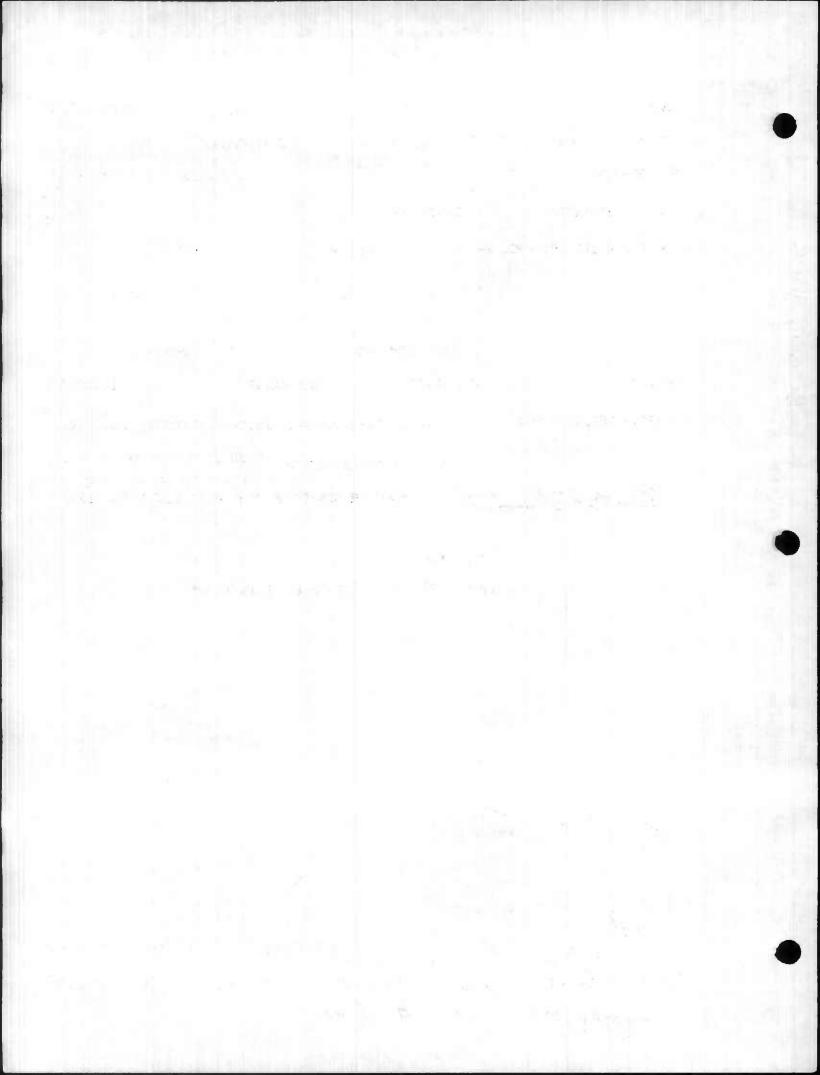
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32. Registrar'a Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		d. Decedent New Co. Co. Co.	State of Ma		Certific				Reg. No.	6	13/1
Physic /Medi		Decedent's Name (First, Middle, La ANNA			BESSER			2. Date of D Month AUSU	st 28	Year 1999	3. Time of Death
Funeral Director		4a. Facility Name (If not institution, gives 1.5) 5. Social Security Number 2.16-39-51.74 Usual Residence of Decedent 10a. State MD BALTIMOR	pital of 7. Age	74 10c. City, Town	n or Location	nder 1 Yaar	4b. City, Town, or I Ball If Under 24 Hrs. Hours Min.	more	irth (Pay, Year)	9. Birthple Countr UKRA	ace <i>(Stete or Foreig</i> Y) INE d. Inside City Limits
ith the Marylan or 28a-f ehow	Director	10e. Street and Number		BALTIM	10f.	Zip Code			10g. Citizen of	What Countr	1□Yes XXNo
(27, Anna Within 72 hours after death with the Maryland with 72 hours after death with the Maryland ane. Then "natural", or frems 23a or 28s-1 ehow the Maryland and an article of the Maryland and article of the Maryland article of the Maryland and articl	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decadant E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Datas:	ver in U.S.	13. Was De	ecedant of h specify Cub s 2X No	Hispanic Origin? (S an, Maxican, Puert Specify:	pecify Yes or N o Rican, atc.)		ce - America ck, White, at WHITE	
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Bess laryland 2 2 should be filed and Mental Hygi is marked other	To Be	17. Father's Name (First, Middle, Last) SCHNAER		ATHEVMA	N		18. Mother's Nan SCHANGEL		e, Meiden Sumar		JKNOWN)
Baltimore, Marylis pemit. Pages 1 and 2 should Depertment of Health and Mer Important: If them 27 is marke any injury or other traumatic once.		DIMITRIY BESSER / 20a. Method of Disposition X Burial 2 Cremation 3 Comparison 5 Other (Specification 2) 21. Signature of Funeral Service Licer	Removal from State y)	20b. Place of cemeter. HAR SI	NAI CO 22. Name	Name of or other piese of or other piese of other p	ATION Person Facility SOI ERSTOWN F	Date 3/30/99 LEVINS ROAD PIE	20c. Location OWINGS SON & BR KESVILLE	MILLS, OS. IN, MD. 2	m, State , MD. NC. 21208
Physician /Medical Examiner	iner	23a. Par1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting In death)	a. Se	PSIS Jue to (or as a c		of):	ral D			1	Approximate interval Between Onsat and Death
death certificate be assecute e attending physician ended for use as the bunal-trent	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauae (Disease or injury that initiated events resulting in death) Last	C	Oue to (or as a c		of):					
P.O.	Physician/M	Part II. Other significant conditions of	ontributing to death but	t not resulting in	the underlyin	ng cause giv	ven in Part I.	1770.10	tobacco use co	ntribute to t	the cause of deeth
ecords, P.O aw requires thet the ss been signed by th	Completed by							24a. Wa	s an autopsy formed?	avail	e autopsy findings lable prior to pletion of cause eath?
f Vital Rec ysician: The law is centificate has b director, page 2 s	Be Com	25. Was case referred to medical axaminer?					26. Place of Dea		Yes 2 No	10	Yes 2□ No
Sion of tending Physical Cort. After this the funeral di	Certification: To	1 Yes 2 No 27. Manne of Daath 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		Year) 28b. T	rime of njury M		4 LI Nursing H	28d. Describe	idence 6 Otto	red	
DIVISI To the Hospital or Attention within 24 hours after death of the Furnerel Directors completely filled in by the	ai Certi	29a. Certifier 1 Certifying Ph	building, efc.	(Specify) my knowledge,	, death occurr	red at the tir	me, date and place	City or To	own, State) cause(s) and m	anner as sta	ted.
To the Ho within 24 I	Medical	29b Signatur and a cartifier 29b Signatur and a cartifier 20c Name and address of person who	ilner: On the basis of e and manner state	ed.		29c. Licens	se number		29d. Date signe	d (Month, D	ay, Year)
Sta Registr	_	Sean MGanta (Month, Dey, Yeer)	- 0 .	01 W	Beli S.	Sport	5 000 ere. B	altim	ione, m	10 2	1215



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

UNKNOWN	99-190	BRUCE	BRADY

UI	NKNOWN S	99-	190 BRUCE BRADY	State of Maryla		riment of r		лептат пу	Reg. No. 9 9	27:	372
	Physici	an	1. Decedent's Nema (First, Middle, Las	Brade	10			2. Date of Do Month AUG		Year	Time of Death
	/Medic Examir		4a Facility Name (If not institution, give		AMROCK D		4b. City, Town, or L BALTIMO	ocation of Deal			223 111
	Funeral Director		Social Security Number 6. So		s. last birthday) Yrs.	If Under 1 Year Months Days	H Under 24 Hrs. Hours Min.	8. Dete of Bi	orth ay, Year)	9. Birthplace (Country)	(State or Foreign
	fand		Usual Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Loc	ation				10d. In	side City Limits
	Se-f sh	ctor	Md. NA		Balti	more				11	es 2□No
	death with the Maryland ms 23s or 28s-f show r must be notified at	P	3511 Pilha	Arme		10f. Zip Code			10g. Citizen ot V	Whet Country?	
020	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or flems 23s or 28s-f show immite event, the Medical Executer mante be notified as	by Funeral Director	11. Manitel Status 1☑ Never Merried 2☐ Merried 3☐ Widowed 4☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		es Decedent of H Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	o- 14. Race Blace Specify	e - American Inc ck, White, etc.	dien,
2-00	72 hou netura		15. Decedent's Ed (Specify only highest grad	ucation	(Give k	nt's Usuel Occup	during most of worl	king	16b. Kind of Bu	usiness/Industry	CIN
21215-0020	Jene.	Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	life. D	NOT use retire	1		Harto	rd Ir	situtes
Maryland	should be filed nd Mental Hygi marked other amatic event, t	To Be C	17. Father's Neme (First, Middle, Last) Bruce Bros	dy				e (First, Middle	, Maiden Sumam	e)	
	alth a 27 ls Y tra		19a Informent's Name/Relationship (7		19b. Meiling 3510 Place of Disposi	· Pelt	end Number of Ru	e . So	Himure,	Marylo	d
Baltimore,	permit. Pages Department of Important: If it any Injury or o		20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify 21. Signeture of Funeral Service Licens 23a. Pert1. Entertun risease, or compandok, or he Hallure. List only of	Removel from State	yt. Zi	Name end Addre	neteral lass of Facility P.C. F	13-99 Eineral Orrespiretory	Hone & alto. 1	none les	Tarylon
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in deeth)	a. Gunshof Due to	Warrels (or as a consequ		Arm and	Back	of Chest		
oʻ	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or es a consequ	ence of):				1	
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunial-transit		Ceuse (Disease or injury thet initieted events resulting in death) Last	c. Due to	(or as a consequ	ence of):					4.69
Box	death certifi se attending ed for use as	Physiclan/M	Pert II. Other significant conditions co	ntributing to death but not re	sulting in the und	lerlying cause giv	ven in Pert I.	23b. Dld	tobacco uee cor	ntribute to the	cause of death?
P.0	that the ed by ti detach	y Phy						10	Yee PSNo	3 Probably	4 Unknown
Division of Vital Records,	aw requires that the de ts been signed by the a 2 should be detached	Completed by	+						en autopsy ormed?	availeble	utopsy tindings e prior to ion ot cause ?
a R	: The lay							105	Yes 2□ No	1 5 Yes	2 □ No
Z Z	ysicien: The is certificate director, pag	To Be	25. Wes case referred to medical axaminer?	Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ DOA Ott	26. Plece of Dee		one) idence 6XXXthe	er (Specify) A	T SCENE
ion oi	를 를 들		27. Menner of Death 1 Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year) \$-29-99	28b. Time of Injury	28c. Injur			how injury occurr		I OSCILLE
Divis	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completaly filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, streetify) Street	,		City or To	(Street and Numb iwn, Stete) 42ct rock Dring	er or Aurel Acuses Blk Robi	rton
	24 hours Funer staly fill	edical	29a. Certifier (Check only one) 1 Certifying Phy Medical Exam	sician: To the best of my kr Iner: On the basis of examir end manner stated.	nowledge, deeth onetion end/or inve	occurred at the tirestigation, in my o	me, date and place, pinion, deeth occur	end due to the	cause(s) and me	nner as stated.	
	To the comple	Me	29b. Signeture end til 60 certifier	011 1		29c. Licens	e number C.M.E		29d. Dete signed	d (Month, Day, 30, 19	
		-	30. Name and address of person who c				Baltimor	re Mars	rland 21		

State Registrar

31. Date filed (Month, Day, Year)
SEP 0 1 1999

32. Registrar's Signature

5. Sports



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Otato of Maryla	Certific				Reg. No. 99	27373
		1. Decedent's Neme (First, Middle, Last)				2. Dete of De	ath	3. Time of Death
Physicia /Medica		EDITH	BROI	D4			AU GUST	27 19	99 2:08 HW
Examine		4a Facility Name (If not institution, give				4b. City, Town, or	Location of Deat	4c. County	of Death
		SINH HOSPITAL O					mone	I IVI	F
Funeral Director		5. Social Security Number 6. Se 15-64-9233 Usual Residence of Decedent	7. Age (In yrs	Yrs.	nder 1 Year ths Deys		8. Dete of Bir	1955	9. Birthplace (State or Foreign Country)
death with the Maryland rms 23a or 28a-f ahow rms 10e rooffied at	tor	10a. State 10b. County N/A	ba	ity. Jown or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith with the 23a or 28	Funeral Director	3105 Dak For	d Ave.	101	2121	5		10g. Citizen of V USA	Vhet Country?
020 urs after al', or its	2	11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Yeer or Detes:		ecedent of specify Cut es 212 No	Hispanic Origin? (S san, Mexican, Puerl , Specify:	pecify Yes or No o Rican, etc.)	Specify	a - American Indian, ik, White, etc. :: Black
d 21215-0020 filed within 72 hours at Hygiene. then "netural", or mit, fre Hydical Euron	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondery (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's (Give kind of life. DO NO	f work done	during most of wor	rking	HOSPit	isiness/industry
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e, Maryla 1 and 2 should Health and Mer am 27 is merke ther traumatic		19a Informent's Neme/Relationship (7) Frances Broid	4	14/0	may	ct. Bal			State, Zip Code)
Baltimore, Nominia Pages 1 and Department of Health Important: If Itam 27 any Injury or other transcent		20a. Methed of Disposition 1 Burlel 2 Cremetion 3 □F 4 □ Donetion 5 □ Other (Specify)		Plece of Disposition cometery, cremetory	(Neme of or other pla	Fery	J-4-99	Lansow	City or Town, State Ne, MD.
Baltim permit. Pag Department Important: I any Injury o		21. Signeture of Funeral Service Licens	not	PACU AACU	e end Addr	ess of Facility	ecal Ho	ne P.A.	21229
		23a. Part1. Enter the disease, or compleshock, or been teiture. List only of	icetions thet caused the deene ceuse on each line.	th. Do not enter the	mode of dy	ing, such es cardie	or respiretory a	rrest,	Approximate Intervel Between
Physician /Medical Examiner		Immediate Cause (Finet disease or condition resulting in deeth)	STATU	S ASTHM	#TICU	ي			Onset end Deeth
	-			or es a consequence					
pen p	Examiner	Samuel Matheritation C	,	ATTON P		OWIA			IMMODINTE
O, o a sage of an an an an an an an an an an an an an	EXB	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	***	or es a consequence	1017.				t 1
2 0 0	edical	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or es a consequence	of):				
Box eath cert attendin for usa	2		1						
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Records, P.O. Box he law requires that the death cer e has been signed by the attendin age 2 should be detected for usa	Completed						24a. Wes	an autopsy ormed?	24b. Were autopsy findings eveilable prior to completion of cause of death?
The lay	E						10	Yes 35 No	1 ☐ Yes 2DYNo
f Vital Re yylcien: The is certificate he director, page		25. Was case referred to medical examiner?				26. Place of De	eth (Check only	one)	1
Of Vital Physicien: This certificat	0	1ØYes 2□ No		ER/Outpatient 30	J DOV		1	dence 6 Oth	
Division of attending Patter death. Director: After I in by the funers	ation:	27. Menner of Death Maturat	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Inju Wo	iryal ork?]Yes 2 □ No	28d. Describe	how injury occur	red
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To the Hospital within 24 hours To the Funeral completely filled	edicar	29e. Certifier (Check only one) Certifying Physical Examination (Check only one)	elclan: To the best of my known of the basis of examination and manner steted.	owledge, deeth occur etion and/or investiga	rred at the tation, in my	ime, date and place opinion, deeth occu	e, end due to the orred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)
To the within 7 To the comple	100	29b. Signeture and title of certifier	/		29c. Licen	se number		29d. Date signe	d (Month, Day, Year)
Λ		12 (8	-	un	Da	9250	10	AUGUST	27 1999
Mil)		30. Name and address of person who co					- 0		
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	•		Decedent's Neme (First, Middle, La	et)		Cei	rtificat	e of	Death		2. Dete of D	Reg. No.		3. Time of Death
	Physic		Milton J. Bishop								Month	Day	999	6:30AM
	/Med Exami		4e. Facility Neme (If not Institution, giv		per)			[4	lb. City, To	wn, or L	ocation of Dee			
			Asbury Methodist	Village	Home						sburg		tgome	ery
	Funeral Director		5. Sociel Security Number 212-10-1334 6. S	ex 7. ⊠ M 2□F	Age (In yrs. la 96	ast birthday) Yrs.	if Under Monthe		if Under Hours	24 Hrs. Min.	8. Dete of B (Month, D Sept.	irth (Pay Year) 1902	9. Birthi Cour Mar	olace (State or Foreigntry) 'yland
	and		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show	tor	Maryland N/A		, , ,	Balti								1 K Yes 2 No
	or 28a	lrec	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	ath wi	ral	3611 Glenmore Ave	nue				1206					ed St	tates
020	or he	by Funeral Director	11. Meritel Stetus 1 □ Never Merried 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Wes Deceded Armed Force 1 Test 2 If Yes, Give Yeer or Date	es? No		Wes Deced f Yes, spec l□Yes		ispenic Ori on, Mexicar Specify:		ecify Yes or N Rican, etc.)		ce - Americ ck, White, y: Whi	
5-0	72 hours "natural",	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		18a. Deced	lent's Usue kind of wo	i Occup	etion durina mos	t of work	ina	16b. Kind of B		
2121	withir than	Be Completed	Elementery/Secondery (0-12)	College (1-4	or 5+)		kind of wor DO NOT us tter					Unit Post	ed St	tates ervice
Maryland 21215-0020	2 should be filed and Mental Hygid Is marked other sumatic event, the	To Be	17. Fether's Neme (First, Middle, Last, Charles A. Bisho	р	·				Mar	gare	t S. M		92.1	
	nd 2 should th and Men 27 is marke traumatic		19e. Informent's Neme/Reletionship (Mr. Don Rogers /				_					ber, City or Town 12 Miami		o <i>code)</i> Orida 3312
re,	ges 1 and 3 it of Health if item 27 l or other tr		20a. Method of Disposition		20b. Ple	ece of Dispo				1	Dete	20c. Location		
imo	Page nent ant: If ury or		1		918	Lawn			,	9	/2/99	Baltimo	re, M	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: if item 27 is any injury or other tra once.		21. Signeture of Funerel Service Licer	Timot	hy Harr -	nan Le 53	onard 05 Ha	d Addre	Ruck	, In	c. Fund Baltimo	eral Homore, MD	e 21214	
t	ė		23e. Pert1. Enter the dise (se, or com shock, or heert fellure. List only	olicetions thet cau	sed the deeth.									Approximate Interval Between
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90,	cats be execute physician and s the burlat-trans	I Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	0.	Due to (or	es a conseq	uence of):			-			1	()
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Records,	r requires been sign should be	Completed by										s an eutopsy formed?	co	are eutopsy findings rallable prior to empletion of cause death?
=	delant: The law certificate has nector, page 2	Соп									1 🗆	Yes 2010	1[□Yes 2□ No
of Vital	cian: sertific sector,	Be	25. Was case referred to medical examiner?	Hospitel:				0#			h (Check only			
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ion	Attending in death, ector: After by the funer	atlor	1 Netural 5 ☐ Pending investigation	28a. Dete of (Month,	Day Year)	injury	м	8c. Injur Work	k? Yes 2□	No			.57	
Division	825 C	Certification:	3 Sulcide 6 Could not be determined	289. Place of	Injury - At hor, , etc. (Specify)	ne, ferm, str	eet, fectory	, office	<u>-</u>		28f. Location City or To	(Street and Numbown, State)	ber or Run	al Route Number,
	五年五年	edical (29e. Certifler (Check only 2 Medical Exam	ysician: To the be siner: On the basi end manner	s of examinetic	iedge, deeth on and/or inv	occurred or estigetion,	et the tin	ne, dete an pinion, dee	d plece, th occur	end due to the red at the time	cause(s) end m , dete and placa,	enner es s end due t	steted. to the cause(s)
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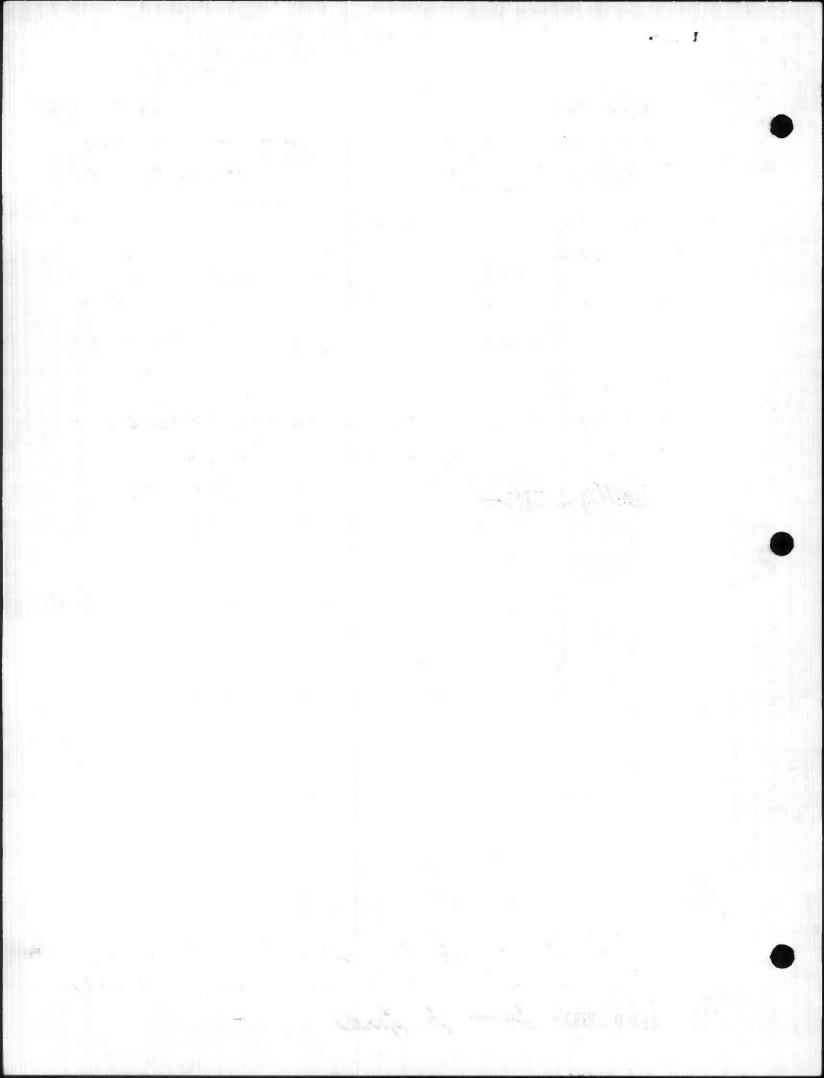
911

md 20179

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MELNICH

John R M 31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 54 am 4b. City, Town, or Location of Death 1999 /Medical 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) April 13,1927 Maryland 6. Sex 1X0 M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 218-22-5119 72 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. Cify, Town or Location 10a. State 10b. County 1 Yes 2 No Director Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 Nasco Place USA 21239 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ♥️ Yes 2 □ No ttYes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, White, etc. 1 Never Married 2 Married 1☐ Yes 2♥ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Textile Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname) Be Mary H. Awalt James F. Bowersox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5715 Nasco Place, Baltimore, Md. 21239 Constance A. Bowersox-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith Cemetery9- 3-99 Baltimore 21. Signeture of Funeral Service Licensee Lary R. Listovanni 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 22. Name and Address of Fecility 5305 Harford Road Baltimore, Md. 21214 ter the mode of dving, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Defural 5 Pending 1 Yes 2 🗆 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

sician and buriel-transit physician s the buriel has cartificata Aftar this

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Haaith end Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23s or 28s-f show eny injury or other treumetic event, the Medical Examinal must be notified at

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760 98 950 signed by the e pinous page 2 s or Attending Physician: funeral director, aftar death. Director: Aft 24 hours a Funeral C Hospital completely within 2 To the

State Registrar 29a. Certifier

(Check only one)

edicai

29b. Signature anglittle of certifier

29c. License number

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

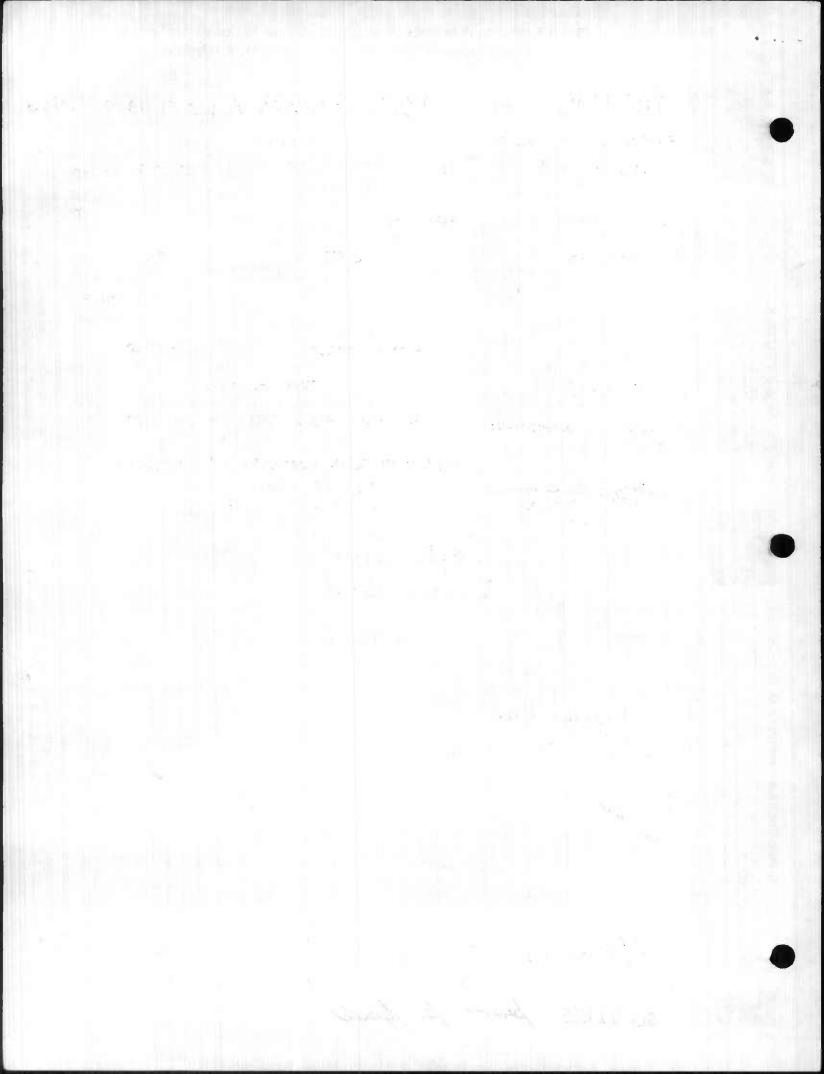
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. 29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

-och

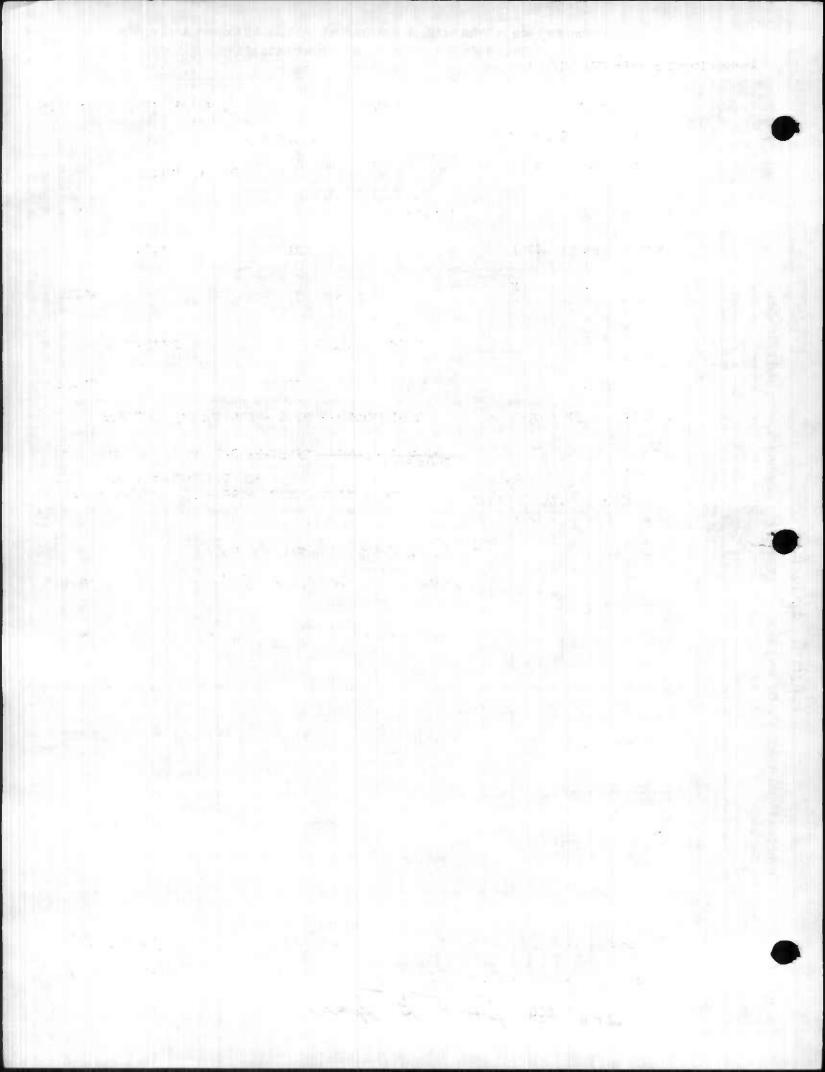
31. Date filed (Month, Day, Year) SEP 0 1 1999

Blod Baltimore 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	1. Decedent's Neme	e (First, Middle	, Last)					Death		of Deeth			3. Time of Death
	Physiciai /Medica	al _		HAROLD				CHAIT			AUGU	IST 2	6, 199		4:00 PM
	Examine	er 4	la Fecility Name (If UNION ME		_					4b. City, Towr BALTIM	n, or Location of	Deeth	4c. County	of Deeth	
	Funeral Director		5. Social Sacurity No. 577–03–]	1070	6. Sax 1 X M 2 ☐ F		(In yrs. last birth	If Un Mont	ndar 1 Yaar ths Deys	If Under 24	Hrs. 8. Dale	of Birth th, Dey, Y	(ear)	9. Birthpl Count	ace (State or Foreign try) MD
	4 show	1	Usual Residence of 10e. Stete MD	10b. County N/A		1	BALTIM							10	0d. Inside City Limits 1 Yes 2 □ No/
4	death with the Maryland ima 23a or 28a-f show must be notified at	۵	10e. Street and Num 3601 GRE		7 #701			10f.	. Zip Code	21218			J. Citizen of V		try?
	or, or he	by Fur	11. Meritel Status 1 Never Marrie 3 Widowed		Armed 1 X Ye If Yes,	ecedent Everage Forcas? es 2 No Give or Dates:			ecedent of the specify Cub os 2 No		n? (Specify Yes Puerto Rican, e	or No-		e - America ck, White, e	
	within 72 ho piene. r than "natur fre Medical	Be Completed	(Special Special	t grede complete	ed) e (1-4or 5+) YEARS		life. DO NO	Usuel Occup f work dona T use retire RESID		of working		Sh. Kind of Bi		lustry	
ryland	2 6 2 0	0		WILLIAM	1		СНА			ZELM					SALTZ
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State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Flagistrair's Signature

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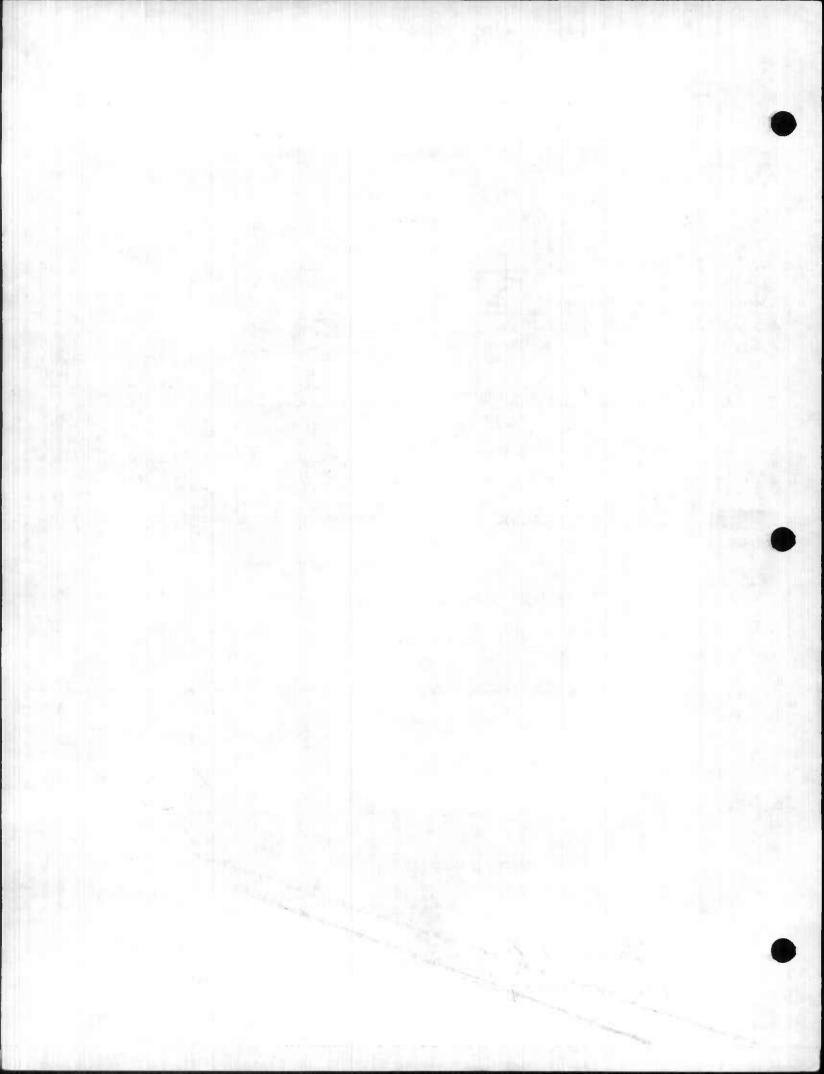
31. Date filed (Month, Day, Year)

SEP

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

August 27, 1999



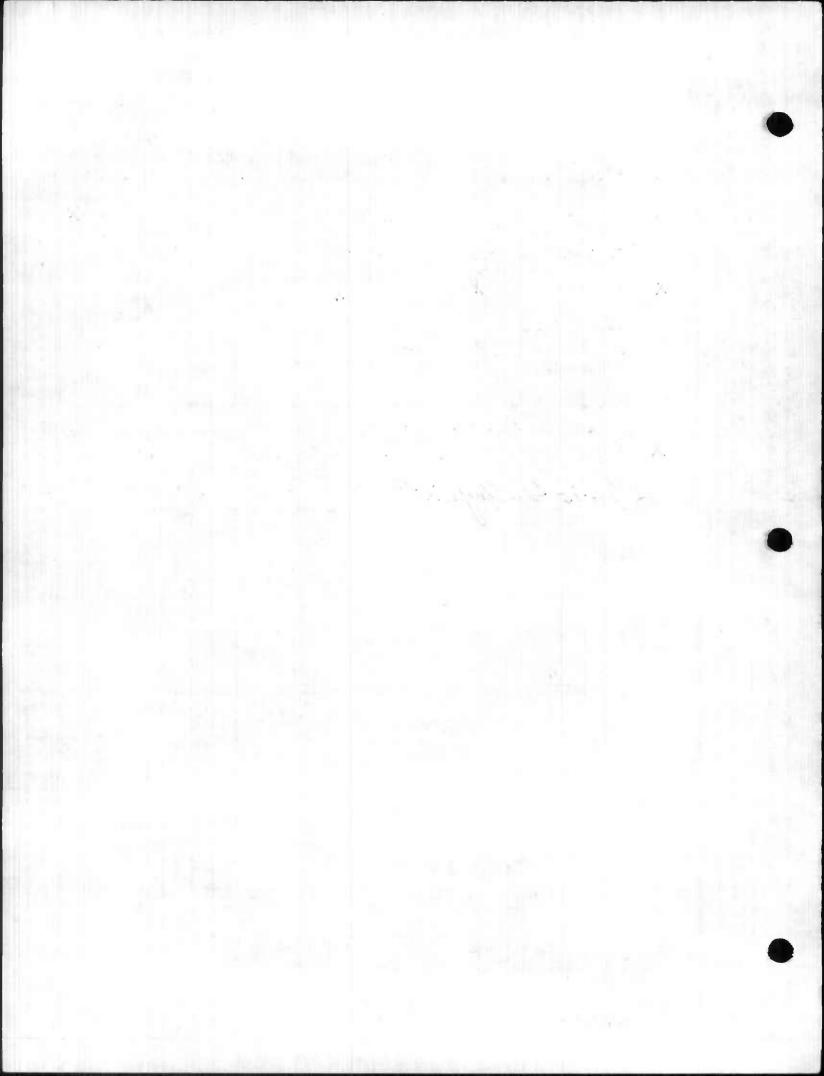
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** August 4:35 Pm 26 VIOLA CARLEST /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital ot Baltimore Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 20 F Director 215 24 7022 11.1922 South Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stata 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow ury or other traumatic event, the Medical Experience must be notified. 1 Yes 2 No Directo MD. N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 3737 PATTERSON AVENUE 21207 U.S. OF A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. I Known as Viola 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK p 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) UNKNOWN UNKNOWN DOMESTIC WORKER PRIVATE FAMILIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 AARON CARLEST EMMA MONTGOMERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3737 BALTIMORE, MD. 212 20c. Location - City or Town, State SHARON HOLLEY (DAUGHTER) PATTERSON VAE. 21207 altimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page Department of Important: If eny Injury or once. KING MEM. PARK 9/3/99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fine al Service Licenses GWYNN²². Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 23a. Part1. Enter the disease, or complications that cannot the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ewis Levynn BALTO MD

Approximate
Interval Between
Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Rena Insufficienc Physician/Medical Due to (or as a consequence of): 82 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ been signe should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes 2 No 1 ☐ Yas 2 No certificate or Attending Physician: funaral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Anpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. tnjury at Work? Certification: 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homlcide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the To the To the F 29d. Date signed (Month, Day, Year) 29b. Signature analytitle of certifie 29c. License number Resouv4uN August 26. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Linell 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar SEP 0 1 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 27, 1999 **Physician** Dorothy E. Coles AUGUST 11:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore 5 Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1□ M 25F Months Days Hours 216-14-0457 Yrs. Director 10/13/1921 Maryland Usual Residence of Decedent death with the Marylend 10a State 10b. County show 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itsms 23s or 28s-f show the Medical Examiner must be notified at Baltimore Baltimore **Funeral Director** 1 ☐ Yes 200No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Road 21206 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, atc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Be Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic i. Pages 1 and 2 should be filed w Iment of Health end Mental Hygie tent: If Itam 27 is marked other th ijury or other traumatic avent, the 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) 2 Richard C. Bauer Estella Mae Hauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquelyn Sweet 8908 Tarpleys Circle Baltimore, Maryland 21237 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2D Burlal 2 □ Cremation 3 □ Removal from State Department of important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Cemetery 8/31/99 Baltimoe, Maryland 21. Signature of Funeral Servica Licansaa 22. Name and Address of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onsat and Death **Physician** /Medical UPPER GASTROINTESTINAL BLEEDING tmmediate Cause (Finat 3 DAYS disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) The law requires that the death certificeta be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai the Due to (or as a consequenca of): for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part it. 23b. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Division of Vital Records, þ 8 Completed paga 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 No ual or Attending Physician: The sterior of the death.

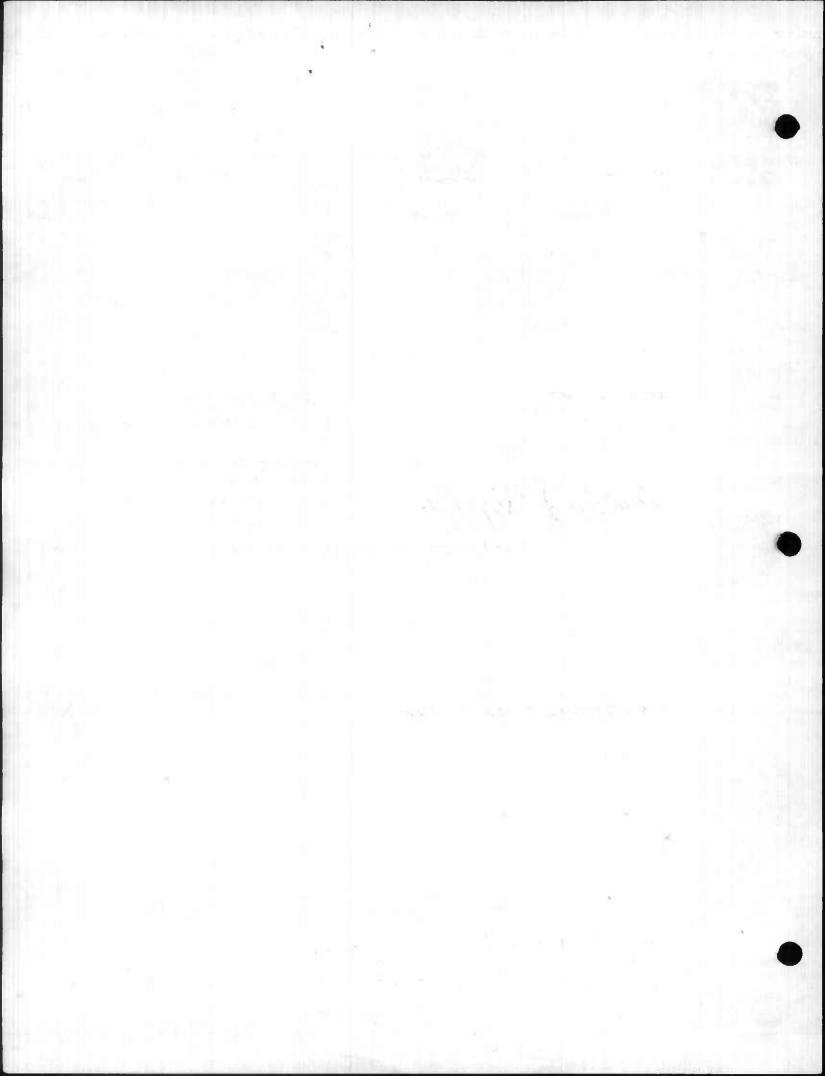
It Director: After this certificat Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA illed in by the funeral 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital To the Hospital within 24 hours e To the Funeral C completaly filled 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) malin, m.o. D41410 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dale of Death AUGV **Physician** 2 Eddie Davis, Jr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Stella Maris Hospice @ Mercy Baltimore NA If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months XXM 2□ F 248-38-3095 70 Yes Director 04-12-29 SC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits natural, or flams 23a or 25a-f show must be notified at MD NA XY Yas 2 No Director Baltimore 10e. Street and Number 10f. Zln Code 10g. Citizen of What Country? 2809 E. Preston Street 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1√ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman Teamster Local #355 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be sent of Health and Mental Inter If Iham 27 is marked of 10 Eddie Davis, Sr. Effie 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2 1 2 1 4 Gerull. Pages 1 and 2. Objectment of Health at Important: If Itsm 27 is any Injury or other tree. 5023 Plymouth Avenue Baltimore, Maryland Azalee Davis 20b. Place of Disposition (Name of cametery, cremetory or other place)
Garrison Forest Vet. 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 9/2/99 Owing Mills, Md. 21. Signature of Funerel Service Licensel 22. Name and Address of Facility Baltimore, Maryland 21202 23a. Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failura. List only one cause on each line. WM.C.March FH 1101 E. North Avenue Approximate Interval Batween Onset and Death **Physician** /Medical Immediata Cause (Final Lung Carre tastatic diseasa or condition resulting in death) Examiner Due to (or es a consequence ot): Examiner certificate be asscuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the Due to (or as a consequence of) attending I for use es P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 2 signed be de Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1□Yes 2☑No 1 Yas 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. 26. Place of Death (Check only one) STELLA MARIS AT MERCY director, Be 25. Was cesa rafarred to medical examiner? Other: 4 Nursing Home 5 Residence 6 XX her (Specify) NOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending Invastigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

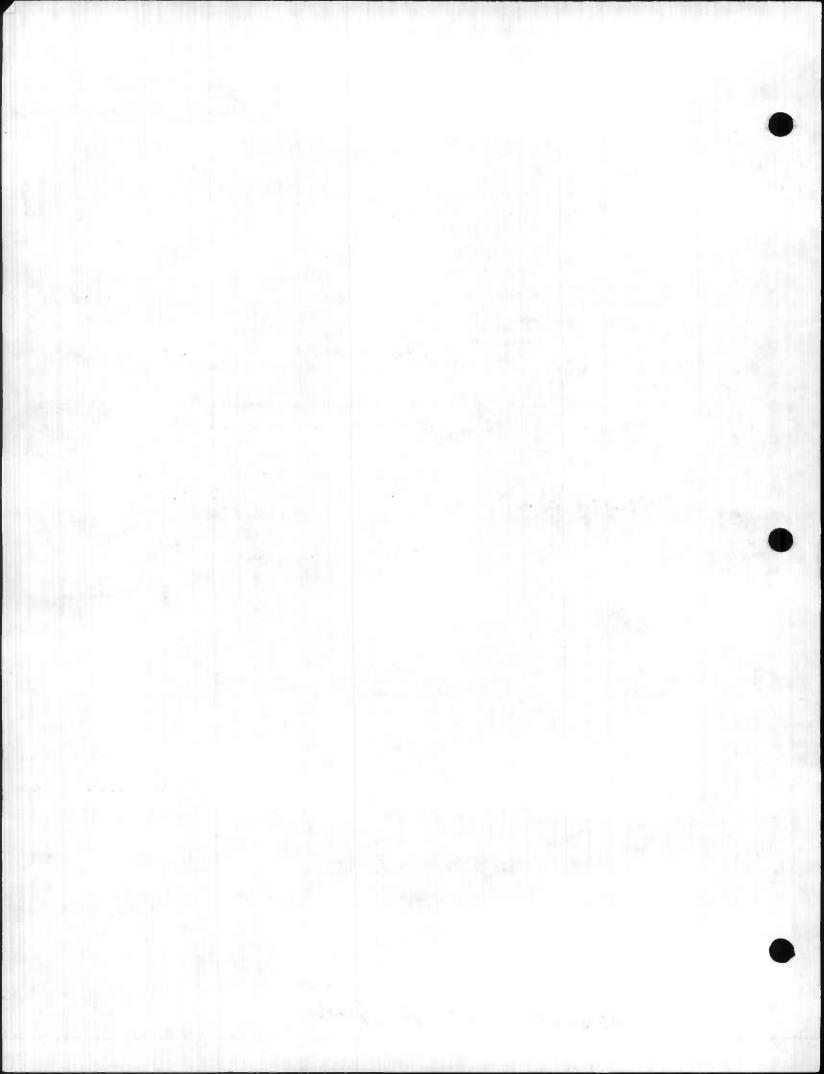
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) 29a, Certifian and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 26/ D40854 94 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kischon 300 SH 21202 Paul Baltmar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

1446

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month g 1)02105 Lillian 0600 AM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Home and hopital Age (In vis. last birthday) If Under 1 Year Baltimore peciality 5. Social Security Number 226-38-6 If Under 24 Hrs. Hours Min. 9. Birthpiece (State or Foreign Country) Age (In yrs. last birthday) 6. Sex 26-38-6263 1□ M 2 F Days 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Location 10d. Inside City Limits Maryland Tes 2 No 10e. Street and Number 10g. Citizen of What Country? U.S. SWeg 14. Race - American Indian, Black, White, etc. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 16 Never Married 2 Married 1□ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 1ack 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. ON NOT usa retired) 16b. Kind of Business/Industry Elamentary/Segondary (0-12) Collaga (1-4or 5+) omemake. 18. Mother's Nama (First, Middle, Maiden Sumame) U W. J. 17. Father's Name (First, Middle, Last) Staves eroy 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Kose er-Daughter OSWEGO 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition-20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Funda Service Licent 1639 N. Bradue to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest Immediate Cause (Final diseasa or condition resulting in death) Esophageal 4 worths Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes an autopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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Director

by Funeral

Completed

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Depertment of Health end Mentel Hygiene. Important: if flam 27 is marked other than "natural", or items 23a any injury or other traumatic event

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the Innertal finestor, page 2 should be detached for use as the burial-transit Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last Physician/Medical

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

4 Homicida

1 Natural

Completed by

Be

Certification: To

Medical

26. Place of Death (Check only one)

BALTIMORE

1 Yes 2 No

21230

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how Injury occurred

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated. 29a, Cartifiar 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date aigned (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

Hospital:

5 ☐ Panding Investigation

6 Could not be determined

038675

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

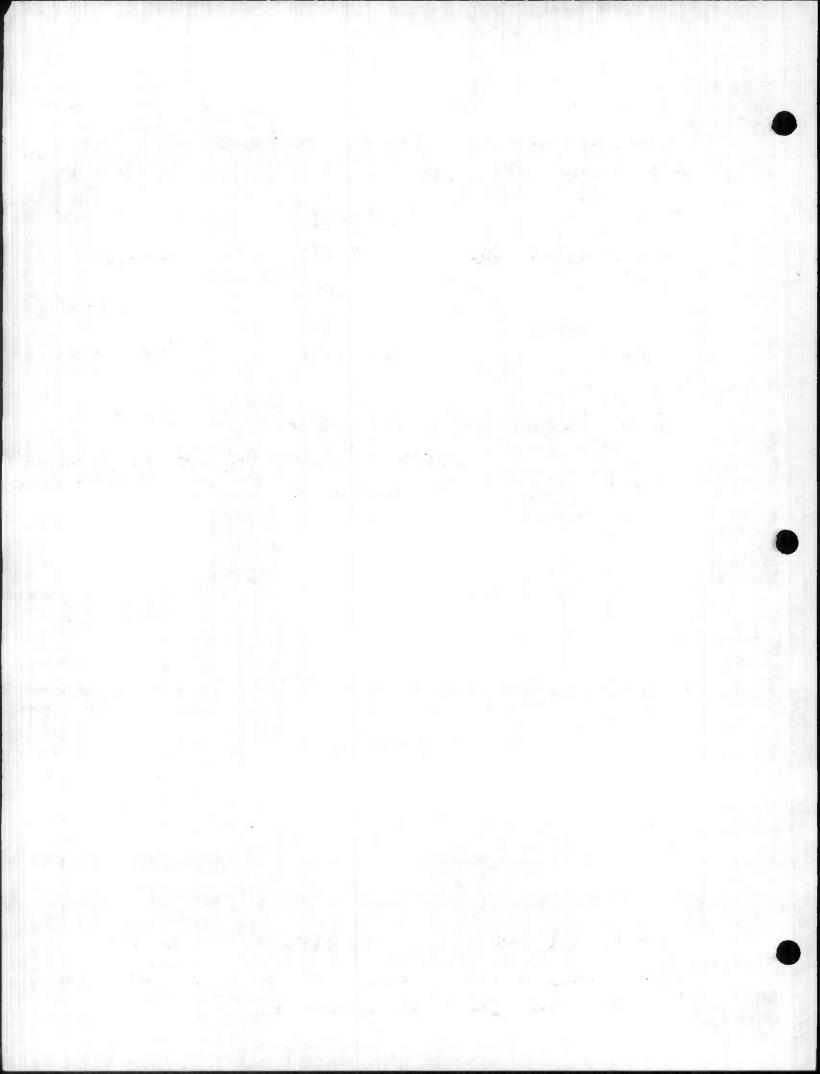
MESHULAM HANOVER 1147

State Registrar

32. Registrar's Signature

28a. Data of Injury (Month, Day Year)

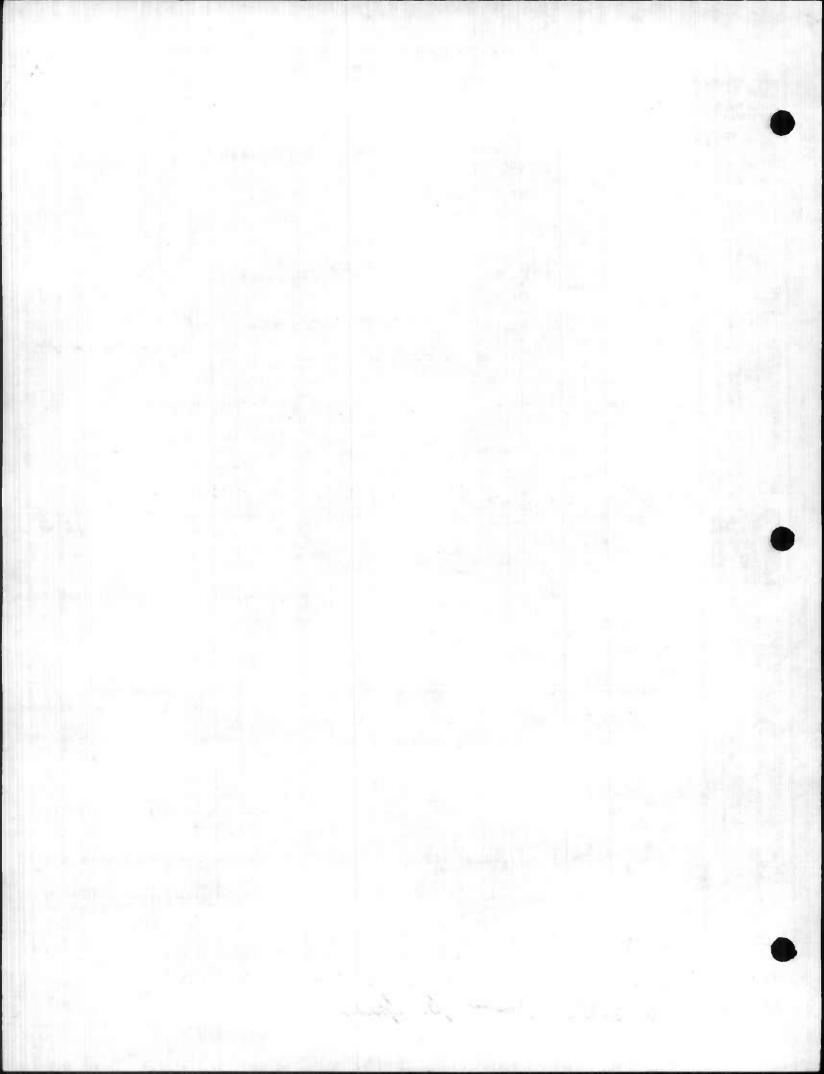
ST



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Vera Ida Fisher August 30, 1999 1:25AM /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Gilchrist Nursing Center Towson If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 216-20-5718 8. Date of Birth (Month, Pay, Year)
June 27, 1924 Maryland 7. Age (In yrs. last birthday) 9. Birtholace (Stete or Foreign **Funeral** Days 10 M 20 F Months Hours 75 Yrs. Director Usual Residence of Decedent death with the Manyland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23a or 28a-1 shorter the Medical Examiner must be notified at MD N/A Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 United States 1426 Meridene Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11 Meritel Stetus Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.
Int: If Itam 27 Ia marked other than "natural", or ite iry or other traumatic avent, the Medical Examinal. Yes 2 No 1 Never Merried 2 Merried altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 🕅 No Specify: Completed by 3 Widowed 4 □ Divorced Year or Detes: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Maryland State Government Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Mechina Pandolfi Italo Niccolucci 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
12907 Cunninghill Cove, Baltimore, Maryland 21220 19e. Informent's Neme/Reletionship (Type, Print) Mr. John I. Maciolek/Son 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Department of Important: If any injury or once. Dulaney Valley Memorial Gardens 109/03/99 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furtiral Service Lic 22. Neme end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 canoe of f. Elter the disease, of complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory errest, lock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finet . Multiple Myeloma 4 Months diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): or Attending Physicien: The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es e consequence of): Box 68760. physicien Physician/Medical the Due to (or es e consequence of): 88 USB signed by the a d be detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Renal Failure Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? page 2 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificata director. 25. Wes case reterred to medical 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Medical Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 1 Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Panding To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) W.A.Riley GBMC 6701 N. Charles Street, Baltimore, Maryland 31. Dete filed (Month, Day, Year) SEP 0 1 1999 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death tion, give street and number) City, Town, or Location K Under 7. Age (In yrs. last birthday) Birthplace (State or Foreign Days Months 1 M 2 F Bro 10b. County 10g. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -12. Was Decedent Ever in U.S. American Indien. 11. Meritel Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (0-12)College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) al Route Number, City or Town, State, Zip Code) Method of Disposition 1 M Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 00 ther (Specify) 21. Signeture of Fusion Service e, or complications that caused the death. Do no List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final yea disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaceo use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown accide Vascula 24b. Were eutopsy findings available prior to complation of causa of death? 24a. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA

/Medical Examiner the burial-transit The lew requires that the death certificate be axecuted

Physician /Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland neat of health and Mental Hyglene. In what of health and Mental Hyglene. In this if them 21 a marked other than "natural", or thems 23a or 28a-f ahow ury or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic event, the Medical Emistre or other treumatic events.

Department c important: If any Injury or

Physician

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

Physician/Medical Examiner be detached for use es Certification: To Be Completed by page 2 should the funaral director,

25. Wes case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturat 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

within 24 hours after deeth. To the Funeral Director: After this certificate has complately filled in by \$

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760,

0 1 1999

29c. License number

29d. Data signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print) 010

10

Court Road Randallstown MO 211

State Registrar

DHMH 16 Rev 6/95

Medical

Milital aut pe in m Lucia South France and the proof of the state of the 27. 1. J. Sales St. 1. 2. 2. 28.3 Hing I'm 129 L. + BROWSE + L. P. J. 1995. the weather the said of the

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 9:00 A.M. 25 L 999 4c. County of Deeth 4b. City, Town, or Location of Deeth HERMAN GORDON 4a. Fecility Neme (If not institution, give street and number) RANDALLSTOWN BALTIMORE Elder Care renesus | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Country) | OCT - 26 - 1938 | South Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1XM 2□F Months 26 5968 60 Yrs. Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits BALTIMORE Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S. OF Α. DOLPHIN STREET 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Bleck, White, etc. 11 Marital Status 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

6614 VINCENT LANE

22. Name and Address of Facility

ZION CEMETERY

RACE TRACK

20c. Location - City or Town, State

BALTO.

MD.

Approximete Intervei Between Onset end Deeth

8/31/99 BALTIMORE, MARYLAND

BALTO., MD. 21215

18. Mother's Neme (First, Middle, Maiden Surname)

GATEWOOD

LEWIS T. GWYNN FUNERAL HOME 21215-6393

B MelRose Are 21212

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

4517 PARK HEIGHTS AVENUE ner the mode of dying, such as cardiac or respiratory arrest,

LABORER

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

GWYNN

Physician /Medical Examiner

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important; if fleen 27 is marked other any injury or other

Physician

/Medical

Examiner

219

10a. Stete

MD.

501

Elementery/Secondery (0-12)

17. Father's Neme (First, Middle, Last)

GORDON 19e. Informent's Neme/Reletionship (Type, Print)

Buriel 2 Cremetion 3 Removel from Stete

21. Signeture of Fundral Service Licenses T.

RUBY GORDON (SISTER)

UNKNOWN

20e. Method of Disposition

RUBEN

College (1-4or 5+)

UNKNOWN

23a. Pert1. Enter the disease, or complications that a used the deeth. Do not enter shock, or heer feilure. List only one cause of each line.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Aw 31. Dete filed (Month, Dev. Year)

SEP 0 1 1999

hWARTZ M.D.

32. Registrer's Signeture

Funeral

Director

r than 'natural', or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

þ

Be Completed

2

Medical Certification:

State

Registrar

The law requires that the death certificate be executed physician and is the buriel-trans 88 signed by the cate hes been sig , page 2 should b

P.O. Box 68760.

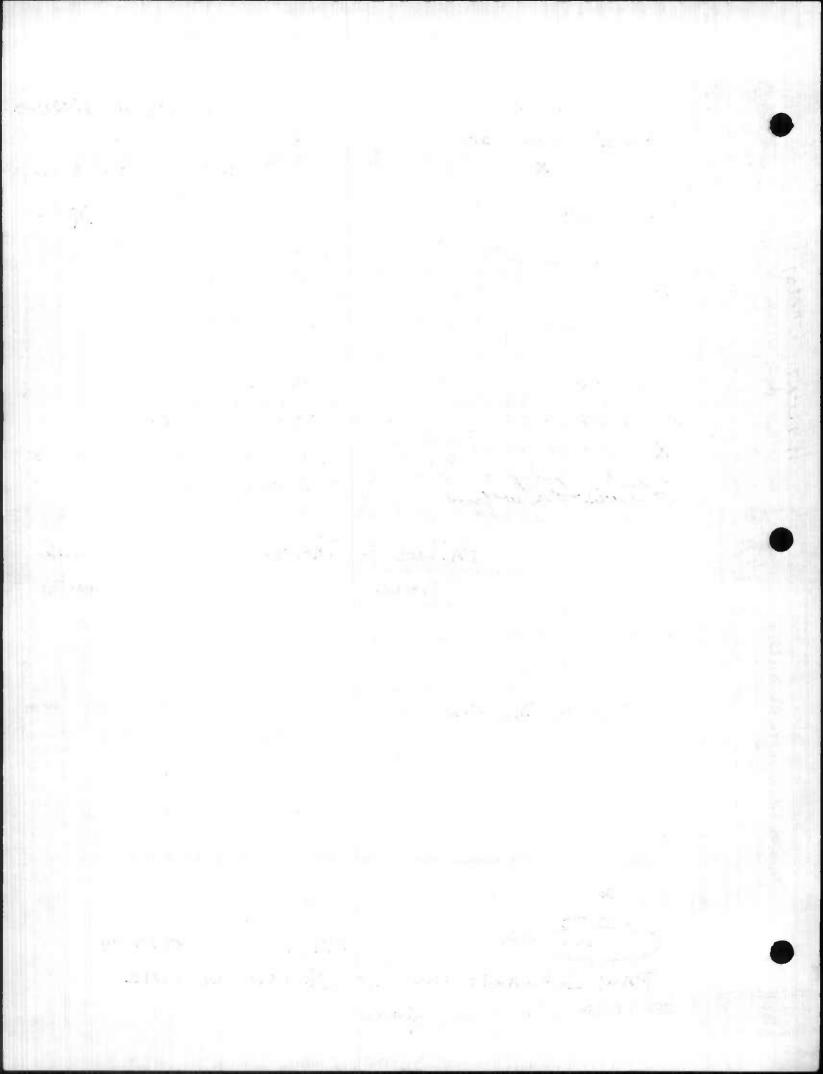
Records,

Division of Vital

this certificate sepital or Attending Physician: hours after death.
Ineral Director: After this certifically filled in by the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the funeral director, for the function director director, for the function director d To the Hospital within 24 hours a To the Funeral C

Immediate Cause (Final disease or condition resulting in deeth) Due to (or es a consequence of) stroke Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dirorder 24a. Wes an autopsy 24b. Were autopsy findings evallable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 28. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpetient 3 | DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

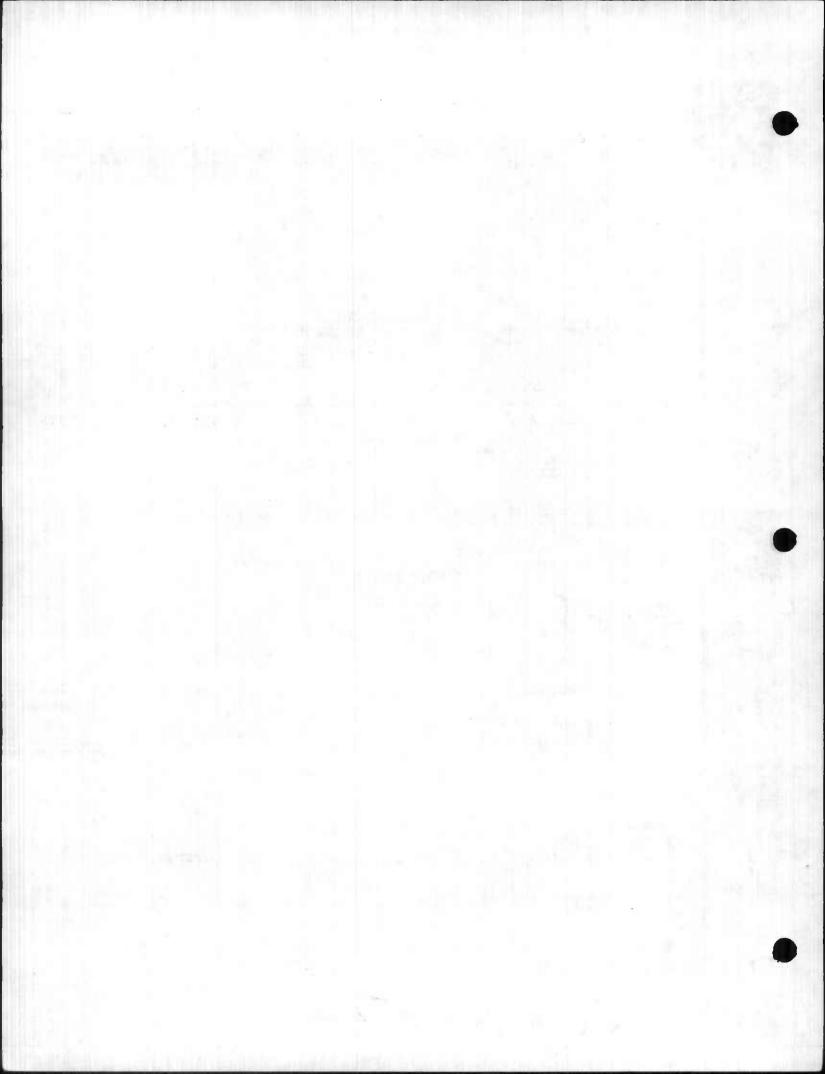
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. 29e. Certifier 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number M.D.



			State of Mar	yland / Depar <i>Cert</i>	rtment of F			giene giene 9	9 2	738	35	
	Physician /Medical			2. Dete of Dea Month August	Day Year		3. Time of Death 3:40 A.M.					
	Examiner			Purnio	1		Location of Death			ndo1		
-	Funeral Director	Mariner Healt 5. Social Security Number 215 16 1498		If Under 1 Year Months Days	Glen I	8. Date of Birth						
		Usual Residence of Decedent					raich z	1 1322	Mal	yrand		
	n the Maryland r 28a-f ahow notified at	Maryland Anne Ar		Oc. City, Town or Local Baltimore					10	d. Inside Cit		
	vith the Ma or 28s-f a be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Counti	ry?		
	ath w			U.S.								
020	72 hours after death with the Maryland natural, or Herra 23a or 28a-f show dical Examinat must be notified at shed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cube ☐ Yes 2 X No	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
21215-0020	도 일을 중	15. Decedent's Ed (Specify only highest grad		(Give k	 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 			16b. Kind of Bus	Business/Industry			
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Maryland	Mental Mental mrked o	17. Father's Name (First, Middle, Last) W	alter Grale	ewski			ne (First, Middle, rances S		s)		, IE	
Mar	0 0 0	19e. Informent's Name/Relationship (7					ural Route Numbe				0.5	
	s 1 end : f Heelth flam 27 other tr	Edward Gralewski		20b. Place of Disposi	Brookwoo	d Road	Date	ore, Mai	-		25	
noi		1 XBurial 2 Cremation 3 4 Donetion 5 Other (Specify		Holy Cros	atory or other place		8/28/99	Baltimo			and	
Baltimore,	permit. Pege Department of Important: If any injury or pose.	21. Signature of Funeral Service Licen		/ 22.	Name and Addre	ss of Facility	Gonce F	uneral H	lome :	P.A.	4410	
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or cours shock, or heart failure. List only the limited late Cause (Final disease or condition resulting in death)	. Cerel	Contract Contract	r the mode of dyin	ng, such as cardia				Approximete Interval Betwo	Ween	
x 68760,	at the death certificate be assecuted by the attending physician and letached for use as the buna-transit.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	¢.	e to (or as a conseque								
Box	death certific e attending p ed for usa as											
P.0.	that the do ned by the detached	Part II. Other significant conditions co	intributing to death but n	ributing to death but not resulting in the underlying cause given in Part f.					23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
Records	been sign should be	1.70					24a. Was a	an autopsy med?	evai	re autopsy fi ilable prior to apletion of ca eath?	0	
	The law page 2						101	es 2 No		Yes 2□	No	
Vital	ystclan: The I is certificate hi director, page To Be Corr	25. Was case referred to medical examiner?				26. Placa of De	ath (Check only o	ne)				
o	Affer th funeral	1 Yes 22 No 27. Manne of Death 1 Netural 5 Pending 2 Accident investigation	1 Inpatient 28a. Date of Injury (Month, Day Yo	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Unit Injury 28c. tnjury at Work?				4⊌ Nursing Home 5 ☐ Hesidenca 6 ☐ Other (Specify)				
Division	the Hospital or Attanding P hin 24 hours after death. the Funeral Director: After inpletely filled in by the funer Aedical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				ber,	
	hound hound	29a. Certifier (Check only one) 1 Certifying Phy	rsician: To the best of miner: On the basis of example and manner stated	amination and/or Inve	occurred at the tinestigation, in my o	ne, date end place pinion, death occi	e, and due to the corred at the time, o	cause(s) and mar date and place, a	nner as sta nd due to	ited. the cause(s))	
	To the He within 24 To the Fu complete	29b. Signature and title of cartifier	e number				Pay, Year)					
	/	Nam S. A	aymen	n M.D	D2	6307		8/26	190	7		
	5	30. Name and address of person who c	ompleted cause of deat	h (Item 23a) (Type, P	rint) R	ANIS.	MRIPI	NENI	1 1			
	State Registrar	31. Date filed (Mornin Bay: Year)	32. Registrar's	Signature 9.	Spork	1 (1)	2100	1			٠	

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) SSIE Mal Hammonds August 0637 26 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Baltimore Memorial tuspital nion 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1□M 2⊠F Months Days Hours 250-32-5675 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location. Ba Himore 1 Yes 2 No NA Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Millington ,5 21223 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2D No Black Specify: 3 DWidowed 4 □ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Courty College (1-4or 5+) Etementary/Secondary (0-12) Public Schools 11th NA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) bert Kennedy Jones line 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 271/3 19a. tnforment's Name/Reletionship (Type, Print) Hammonds - Son Blue Road Stone 04 Durham, Vin 20b. Place of Disposition (Name of cametery, cremetory or other p 20c. Location - City or Town, Stele 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State dalls town, Md Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 21215 F. Hi 23e. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. grenue DaNo, My Approximete interval Between Onset and Death tmmediate Cause (Final with sepsis 4 days disease or condition resulting in deeth) Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 ☐ Yes 2 ☐ No reast failure, 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy tes, Hypertension, Peripheral vascular disease marrhea 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stelled. 29a, Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)

Hammond Hospital or Attending Physician: To the Hosp within 24 hou To the Fune completely fi

> State Registrar

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be To

Funeral

Director

treumatic event, the Medical Examiner must be notified at

or other

Department of Important: If any Injury or pace.

Physician /Medical

Examiner

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Physician/Medical

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Items 23a

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Baltimore, Maryland 21215-0020

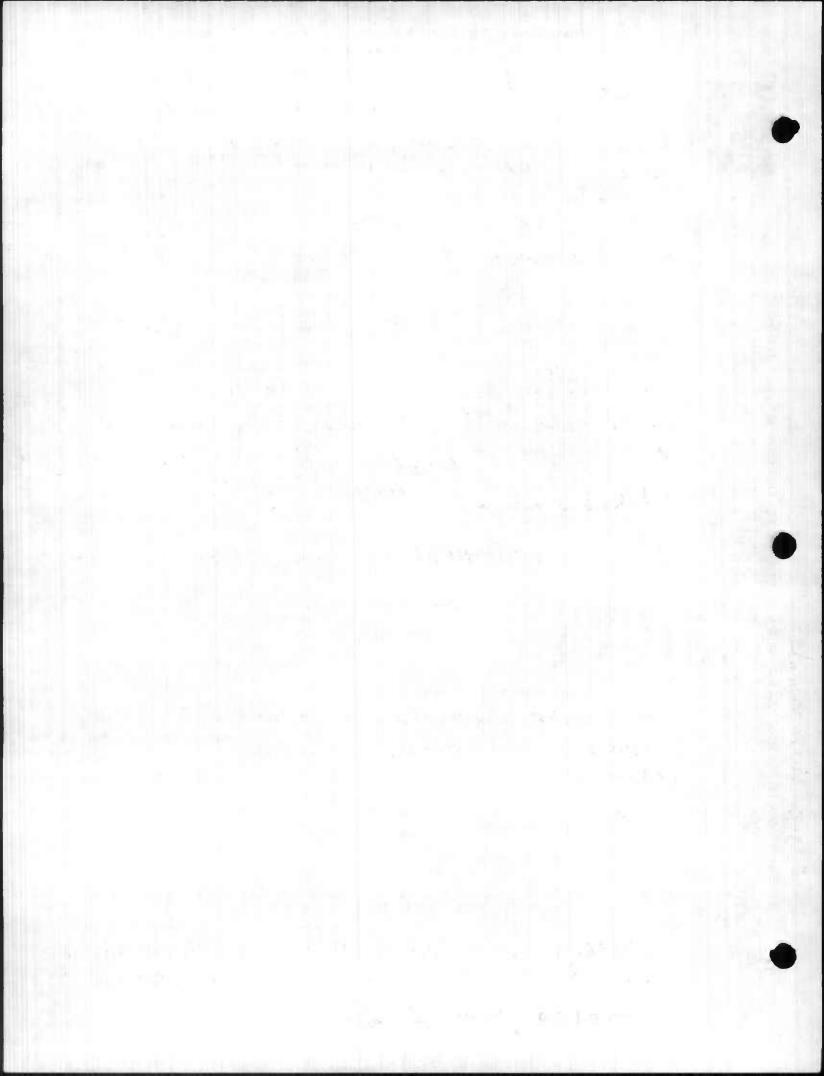
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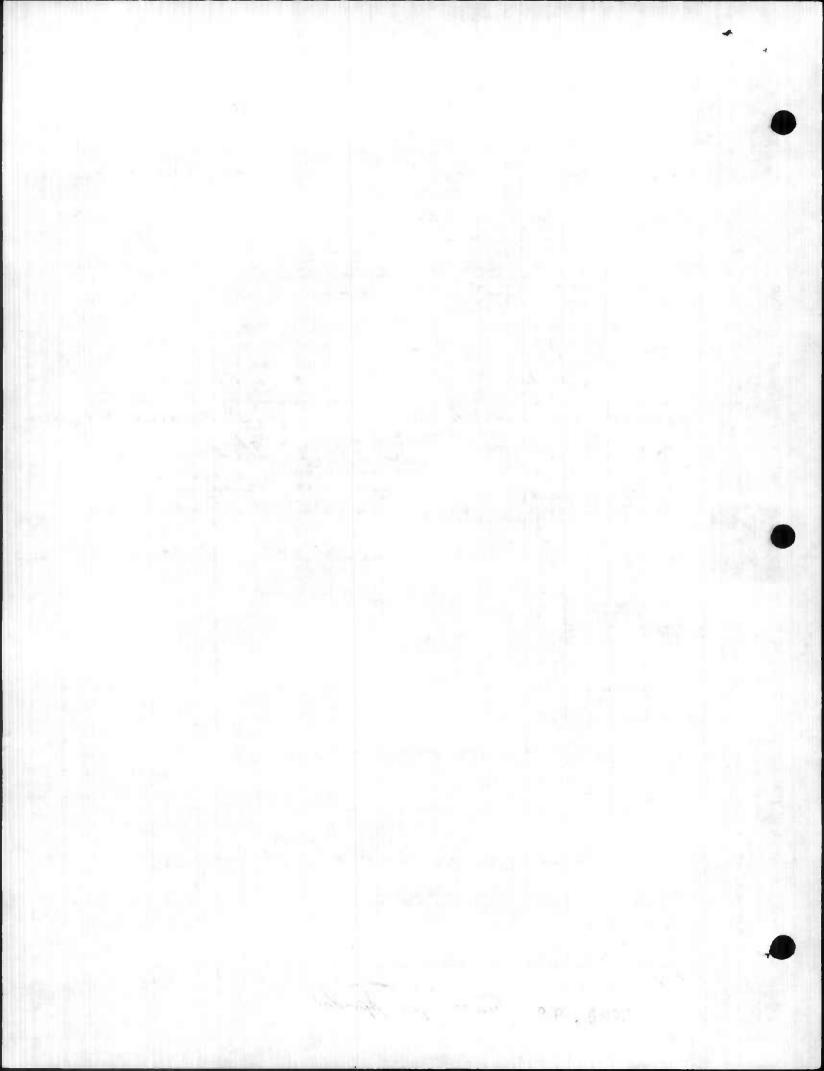
MACAYA DOUDGUIH, MD 32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

East University Pkwy, Balhmore MD 21218



DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Vaar William Honshul AUGUST 1999 4:15AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE H Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8: Data of Birth (Month, Day, Ye Days 10 M 20 F Hours Months 403-30-7528 Aug. 4, 73 Kentucky **Usual Residence of Decedent** 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limite Baltimore Maryland Essex 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Wiltshire Road 21221 U.S.A. 14. Race - Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, atc. 1 Yes 2 No If Yes, Giva Year or Dates: 1 ☐ Never Married 2 ☑ Married WWII 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Army 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-dor 5+) 12 Electronic Tech U.S. Government 17. Father's Nama (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Surname) Charles Honshul Frankie Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Greg Honshul (son) 602 Cranwell Place, Leesburg, Virginia, 20175 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 9/2/99 Andrews Ch. Cemetery Baltimore, Maryland 4 Donation 5 Other (South) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Finance the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) C Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VNS ar

Physician /Medical Examiner

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permit. Pages 1 and 2 Department of Health a Important: If flem 27 la any injury or other trai

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Certification: To

23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 2 00 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) **Hospitat** Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 22 Ho 1 Thpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 PNaturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1G certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha cause(s) and manner as stated. niner: On the basis of exame and manner stated. (Check only one) nination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) 29b. Signature and title of certifier

State Registrar

31. Data filed (Month, Day, Year)

John C

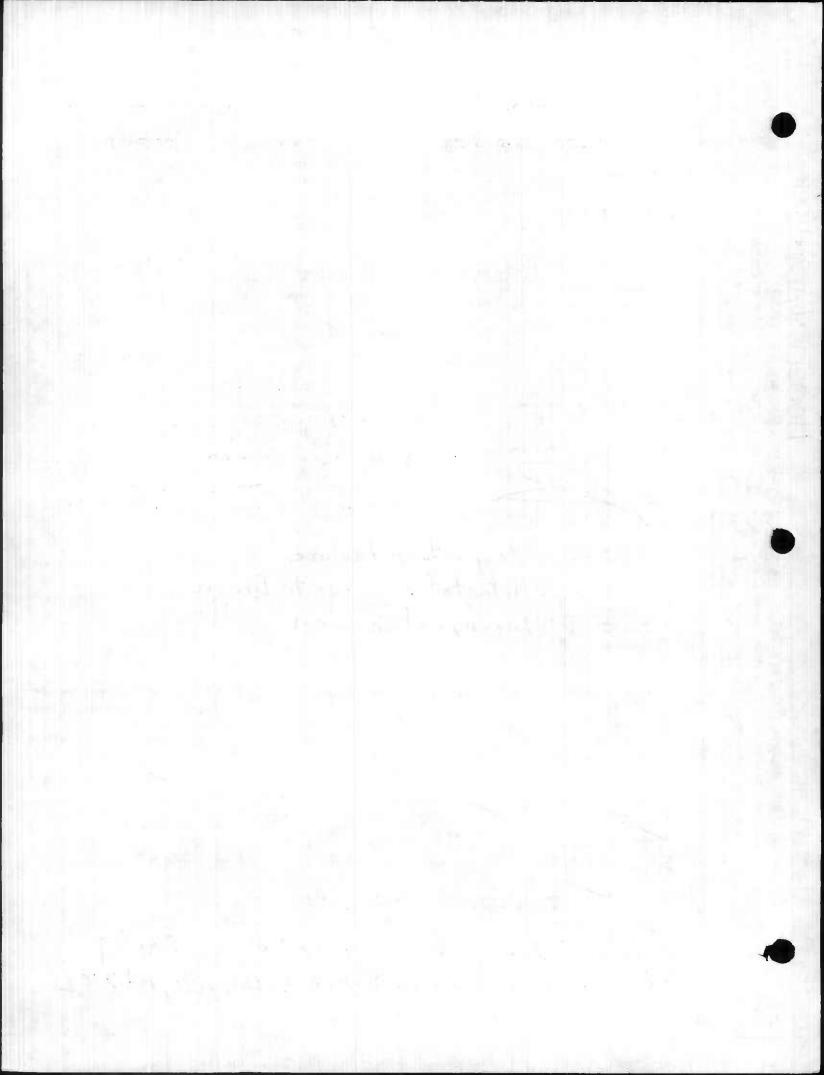
ric

of address of person who completed cause of death (Item 23a) (Typel Print) York

32. Registrar's Signature

29d. Data signed (Month, Day, Year)

Ste 201B, Lutherville, Md 21093

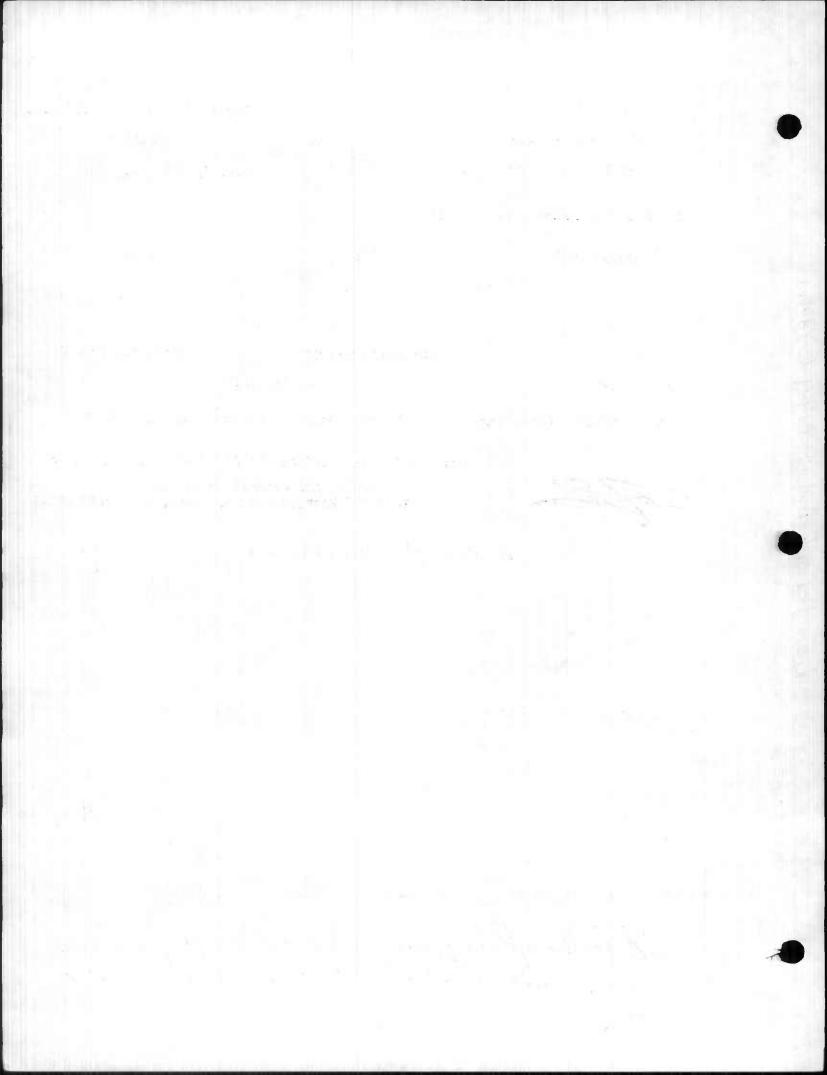


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ner	4a. Fecility Neme (If not institution, giv Gilchrist Hospice				4b. City, Town, or Lo	ocation of Death	4c. County of Baltin			
	5. Social Security Number 6. S		n yrs. last birthda		er If Under 24 Hrs.	8. Date of Birth	+		ece (State or Foreign	
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ō	Maryland Baltimor		Essex	LOOMION				1 ☐ Yes 2 🔀 No		
Direct	10e. Street end Number		10f. Zip Code	0	T 1	0g. Citizen of W	hat Coun	try?		
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o Be C	17. Fether's Name (First, Middle, Last) Alvin Wilson 18. Mother's Name (First, Middle, Maidle,)			
1	19a. Informent's Name/Relationship (18 Brenda Zacharko				eet and Number or Rur Court, Bal					
	20e. Method of Disposition		20b. Place of Dis	position (Name of	1	т.	20c. Location - 0			
	1 Burial 2 Cremetion 3 C			ematory or other						
	4 Donation 5 Other (Specify) Holly Hill Mem. Gardens 9/3/99 Baltimore, Maryland 22. Name and Address of Facility									
	Bruzdzinski Funeral Home, P.A.									
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DHMH 16 Rev 6/95

Lean Helms August 31,1999 @ 8254m 30x 68760, Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Charles S. Harric Sr. 1999 10:38PM AUG. 27. /Medical 4a. Facility Nama (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A SINAI HOSPITAL 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sex 1 M M 2 ☐ F 8. Data of Birth JAN . 22 . 1932 9. Birthplaca (Stata or Foreign **Funeral** Days South Carolin Yrs. 250 46 5671A Director Usual Rasidance of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Weddes Examiner must be notified and 2008. 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits Yas 2□ No N/A BALTIMORE Director MD. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21215 2532 LOYOLA SOUTHWAY U.S. OF A. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 (XYas 2 □ No If Yes, Give Yaar or Datas KOREAN 14. Race - American Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 1 Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No à Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) UNKNOWN FEDERAL PROTECTIVE OFFICER U.S.GOVERNMENT UNKNOWN 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Sumame) CARRIE BELL LIPSEY WILLIAM HENRY HARRIS. SR. 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) MARY H. HARRIS (WIFE) BALTO., MD. 21215 2532 LOYOLA SOUTHWAY 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 9 / 2 / 9 9 20c. Location - City or Town, State BALTO. 1 Buriai 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) OWINGS MILLS.MD.Co. GARRISON FOREST VET.CEM. 21. Signature Tunaral Sarvice Licensea EWIS T. 22. Nama and Addrass of Facility LEWIS T. GWÝNN FUNERAL HOME 21215-6393 Lugar 4517 PARK HEIGHTS AVENUE BALTO. . MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one chose on each line. Approximata Interval Between Onset and Death **Physician** /Medicai Immediata Causa (Final Pobable acuse myoundial disaasa or condition rasulting in daath) Examiner Examiner arterioscler physiclan and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 88 980 for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. detached 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Miknown Àq I wafficience 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has Dage 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attanding Physician: funeral director, 25. Was cesa rafarred to medicel exeminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA the state of 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injuty at Work? After 1 Natural 5 Panding after death. 1 Yas 2 No Invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifian Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signatura and title of certifian 29d. Data signed (Month, Day, Year) 0 30. Nama and addrass of person who complated causa of death (Itam 23e) (Type, Print) ISOM 2300 1 UX 21216

32. Registrar's Signeture

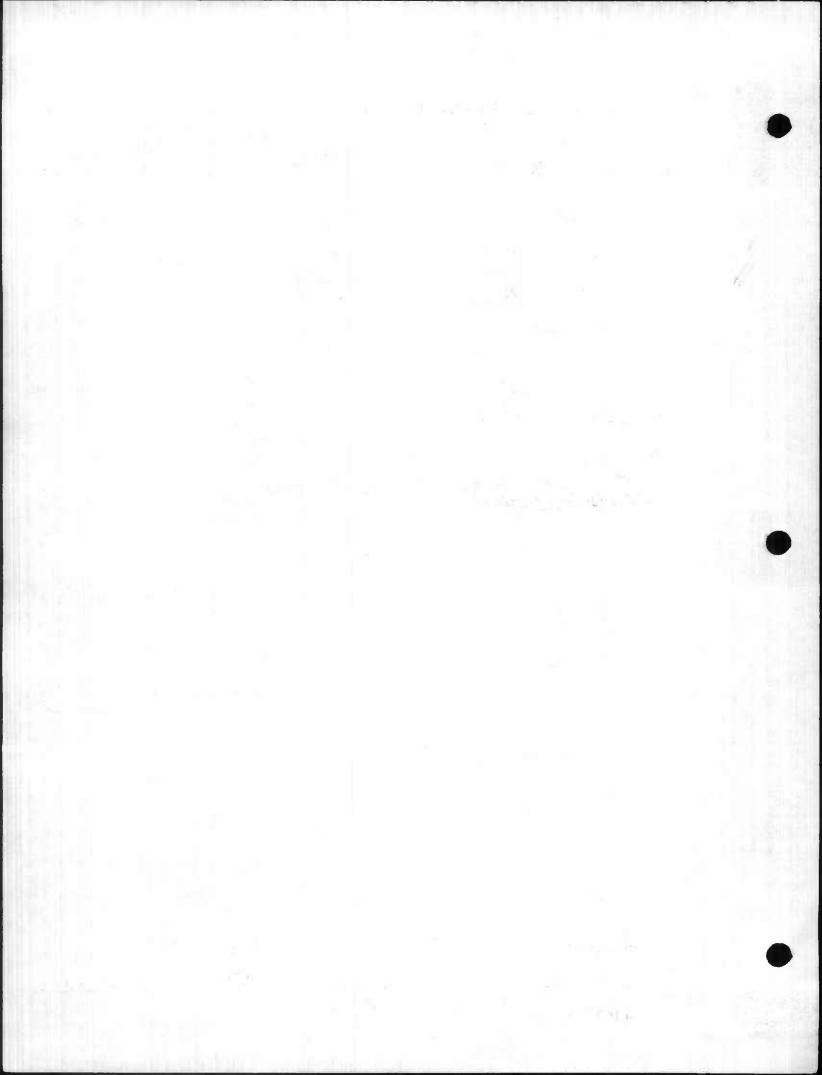
DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

SEP 0 1 1999



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** IRWIN VINSTON 31 1999 August 3:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dundalk Baltimore 7226 Sollers Point Rd H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months M A P 216-01-7517 85 PA Director March 18 1914 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 210 No MD Baltimore Dundalk Directo 25a-f 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 7226 Sollers Point Rd 21222 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No à Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hygiene Auto Manufacture Manager 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be Pages 1 and 2 should be nent of Health and Mental Martha Williams Carl E. Irwin 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) or other tr Sarah Irwin /wife 7226 Sollers Point Rd Baltimore, MD 21222 20b. Place of Disposition (Name of cametery, cremetory or other piece) 20a. Method of Disposition Aug 31 20c. Location - City or Town, State 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 1999 Metro Crematory Catonsville, MD 21. Signature of Funerel Service Licensee 22. Nome and Address of Eacility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 onnel Kony 23e. Pert1. Enter the disease, or complications that caused the doth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** TRansitional Cell Carcinoma of Urinary Bladder,
Due to (or es e consequence of):

Metastatic and locally advanced Immediate Cause (Final disease or condition resulting in death) /Medical 2 years Examiner The law requires that the death certificate be executed Dua to (or as e consequence of): Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Couse (Disease or Injury that initiated events resulting in death) Last Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 Probably 4 ☑ Unknown ('oronary Artery Disease Completed by 24b. Were eutopsy findings svailable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifics Be 25. Was case raferred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pasidence 8 Othar (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifique 29c. License number August 31,1999

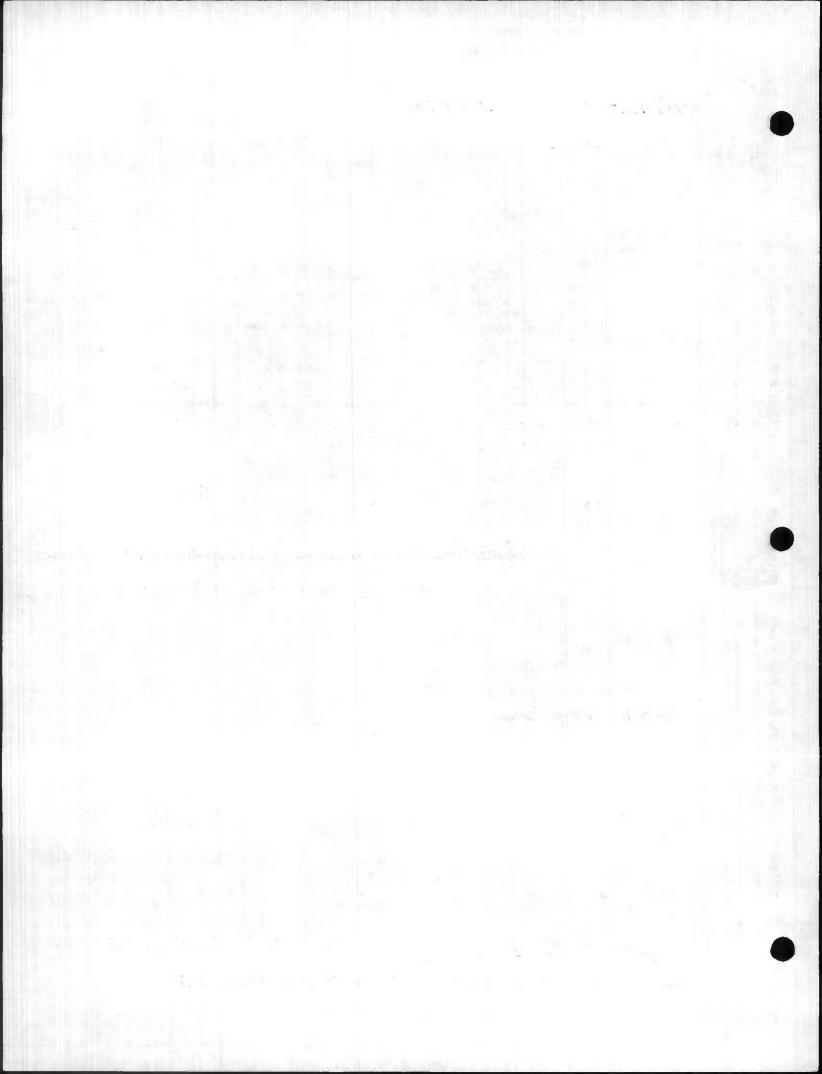
State Registrar 31. Dete filed (Month, Dey, Year) SEP 0 1 1999

Michael Carducci

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

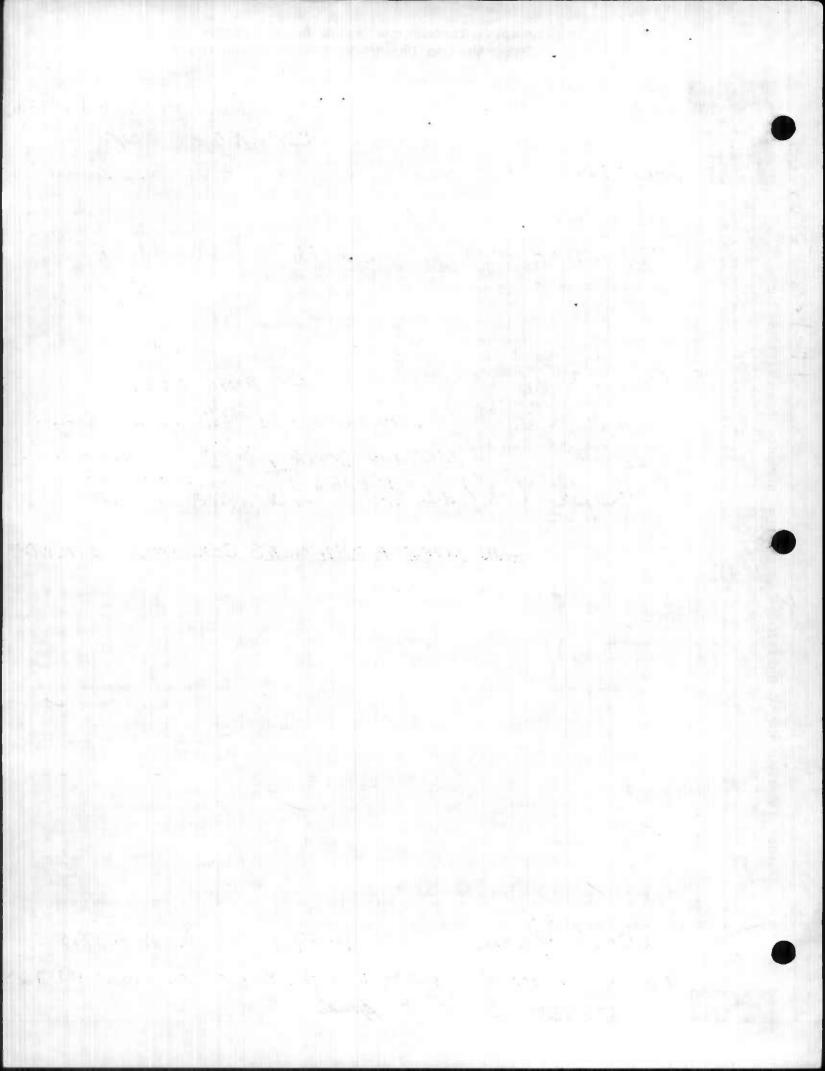
GOON. WOIR ST Baltimore MD 21287 32. Registrer's Signeture

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death **Physician** 2:597m 29 1999 /Medical 4b. City, Town, or/Location of Death 4c. County of Da 4a Facility Name (If not institution, give street and number) Examiner or Home If Under 1 Year Ursing If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplece (State or Foreign 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 M 2 M Director Usual Residence of Decedant death with the Meryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits r 28a-f show show TH Yes 2 □ No 1 Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 916 d Funeral Hack, White, etc. 11. Marital Status 12. Was Decadent Ever In U.S. Armed Forces? 1 Yes 2 2 No Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 72 hours after Frican 1 Never Married 2 Married 1 Yes 2 HNo Specify: If Yes, Give Yaar or Dates: by 3 Widowed 4 Divorged American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) Schoo usTodiar 0 18. Mother's Name (First, Middle, Malden Sumame) 17. Fether's Name (First, Middle, Last) i. Pages 1 end 2 should be file tment of Health end Mental Hy tant: If Nem 27 Is marked oth liury or other traumatic even Be rude seorge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jones 134/11 More Md. 21227 avid 20b. Placa of Disposition (Name of Disposition) of Other (20a. Mathod of Disposition Date 20c Location - City or Town, State Important: If It any Injury or o 1 Durial 2 Cremation 3 Removal from State ON Lowne 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service License 10 W. 1101 and the death. Do not antar the mode of dying, such as cardiac or respiretory errest, 23a. Part Finter the disease, or complications that cauling shock or heart lander. List only one ceuse on each Approximate interval Between Onset and Death **Physician** /Medical THIEMENS DEMENTIA Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-trensit law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) been signed by the should be deteched Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown Division of Vital Records, þ 24b. Were autopsy findinga available prior to completion of causa of death? 24a. Wes an autopsy performed? Completed certificate has b lirector, page 2 s 2 10 No 1 ☐ Yea 2☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ² 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After t 1 Natural 5 Pending Invastigation 2 No Director: A 1 Yes death. 2 ☐ Accident 6 Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(a) and manner es ateted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(a) and manner stated. edical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of castifier 29c. Licensa number Name and eddress of person who completed cause of death (Item 23e) (Type, Print) borah I Pierce PO 7220 Pau Baltimore, MD2 805 1220 Paulc Heights Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State SEP 0 1 1999

DHMH 16 Ray 6/95



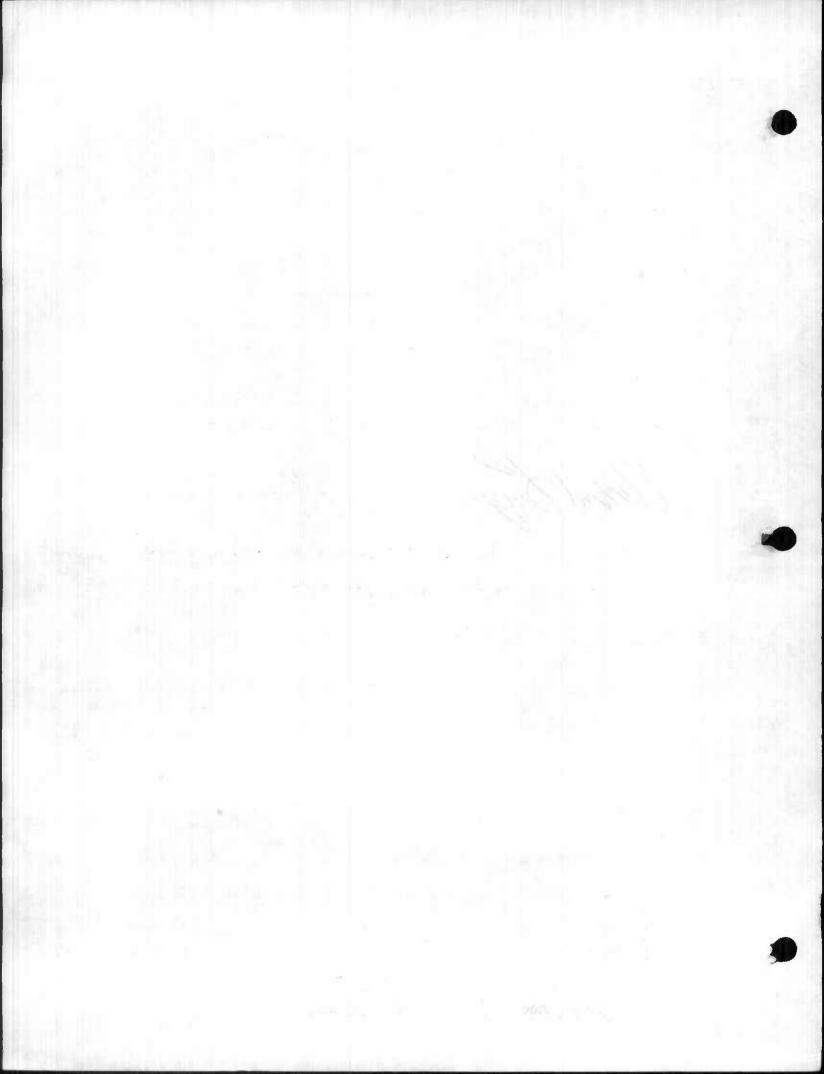
DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3:05 P LLum 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Baltimore Nursing lowson Home If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. 9. Birthplece (State or Foreign Country) Months Deys Min. 1□ M 200 F Hours 219-07-0388 Usuel Residence of Decedent Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limite 1 ☑ Yes 2 ☐ No timore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 100 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Yes 2 And If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Black 3 ☐ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bualness/Industry Elementery/Secondery (0-12) College (1-4or 5+) Domesti 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Nea 19b. Mailing Address (Street end Number or Fural Route Number, City or Town, Stete, Zip Code) 19e. tntorment's Neme/Reletionship (Type, Print) 1701 Eutaw Marc alto, Md. 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location 7 City or Town, State 1 Description 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Joseph 23e. Part / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirator than the disease, or heart failure. List only one cause on each line. Immediete Ceuse (Final diseese or condition resulting in deeth) ACUTE Minules Due to (or es e consequence ot) Due to (or es e consequence ot): Due to (or es e consequence of): Pert II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? PARKINSON'S 1 Yes 2 No 3 Probably 4 Unknown DISEASE 24e. Was en eutopsy pertormed? 24b. Were autopsy tindings eveileble prior to completion of cause of deeth? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer man be notified at

Baltimore, Maryland 21215-0020

Physician/Medical Examiner hysicien end the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest 80 been signed by the attending should be deteched for use

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Medicai Certification: To

page 2

After

within 24 hours efter death. To the Funeral Director: A

filled in by

completely

25. Wes case reterred to medical exeminer?

1 Yea 2 No 27. Manner of Deeth

1 Maturel
2 Accident

5 Pending investigation 6 Could not be determined

28e. Dete of Injury (Month, Dey Year) 28b. Time of 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Sulcide

4 Homicide

Descritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner stated.

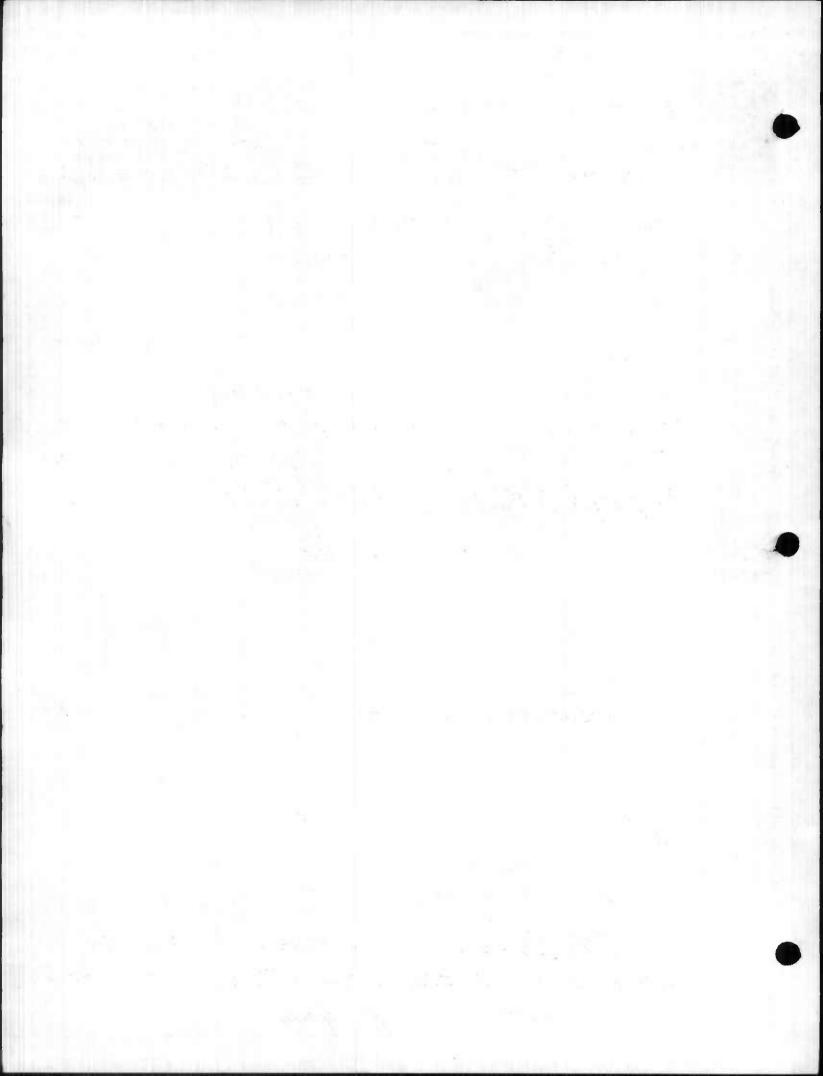
29b. Signeture end title of certities

29c. License number D12849 29d. Dete signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

OSLER Dr. Touson. Md 21204 GHILADI. MD 7600 31. Dete tiled (Month, Dey, Yeer) 32. Registrer's Signeture

State Registrar



99-4979-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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TIMOTHY			Maryland					nd M	ental Hy	giene	9 9	7200
LYDE AMEND	ITEMS: # 23 PART I, 27		75 9-13-9	9. Cer	tificate	OT L	eatn		2. Dete of D	Reg. No.	2 1.	3. Time of Death
Physician	110101231 2011 1 2 2220	Timoth	v 1 i	yde					Month AUGUST	Day	Year 999	6:30P.M.
/Medical Examiner	As Cartille, blance March to ettern		V	yue		45	. City, Tov		cation of Dee			0.301.11.
Examiner	703 N.HOWARD S	TREET					BALT	IMOR	E			
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p R w	Usuel Residence of Decedent 10a. Stafe 10b. County		10c. City, T	own or Loc	ation						1	Od. Inside City Limits
Mary Heth Beda	Md N/A Baltimore										1 X Yes 2 □ No	
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020 urs afte aff. or it Examin by Fu	1 Never Married 2 Merried 3 Widowed 4 Divorced	If Yes, Give	Yes 2 No es, Give 1 Yes 2 No						Specify: Black			
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Baltimore, semit. Pages 1 ar Separtment of Hea mportant: If New 7 my injury or other mos.	4 Donetion 5 Other (Spe 21. Signeture of Funeral Service Lic		Meado		Name and A				-2-99		3-,	
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Physician	shock, or heart feiture. List on	ily one cause on eac	ch line.								i	Onset and Deeth
/Medical	tmmediate Cause (Final disease or condition		DIALTED CA	ARDIOMY	OPATHY						1	
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and Il-tran	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate											
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687 ficate fica ficate ficate ficate ficate ficate ficate ficate ficate ficate												
P.O. BOX 68760, at the death certificate be executed by the attending physician and etached for use as the bunal-transit Physician/Medical Examir		d										
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DIVISION (but or Attending P is after deeth. al Director: After t ied in by the funer Certification:	3 Suicide 6 Could not determine	ad 288. Place 0	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)					1	28f. Location (Street and Number or Rural Route Number, City or Town, State)			il Route Number,
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To the Hooptal o within 24 hours at To the Funeral Di completely filled is Medical Cer		and manne	r stated.		29c. L	icense	number			29d. Date signe	d (Month	Day, Year)
F 3 F 8	O.C.M.E. AUGUST 24,1											
	30. Nama and address of person wh	o completed cause	death/(Item 22	ta) (Type F			41.1.		1	100001 2	・マ・エブン	/ /
	Atomort Mikin	- 1	Joseph (Horn 20			enn	Stre	et,	Baltim	ore, Mar	yland	1 21201
State	31. Dete filed (Month, Day, Year) /	-	listrar's Signaturi		-	-						

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 29", 1999" HELEN LOUISE LIPSON 5:45 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2424 FOREST GREEN ROAD BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2 F 218-18-2242 76 Director JUN. 28, 1923 MD Usuel Residence of Decedent the Mandand 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE Director BALTIMORE 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be 2424 FOREST GREEN ROAD 21209 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck. White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 ☐ Merried 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 PROPRIETOR MARKETING RESEARCH 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental is marked ALBERT L. HAAS BEATRICE GOLDSMITH 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a If Item 27 is or other trau ALICE MOFFET / DAUGHTER 3127 OLD POST DRIVE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition

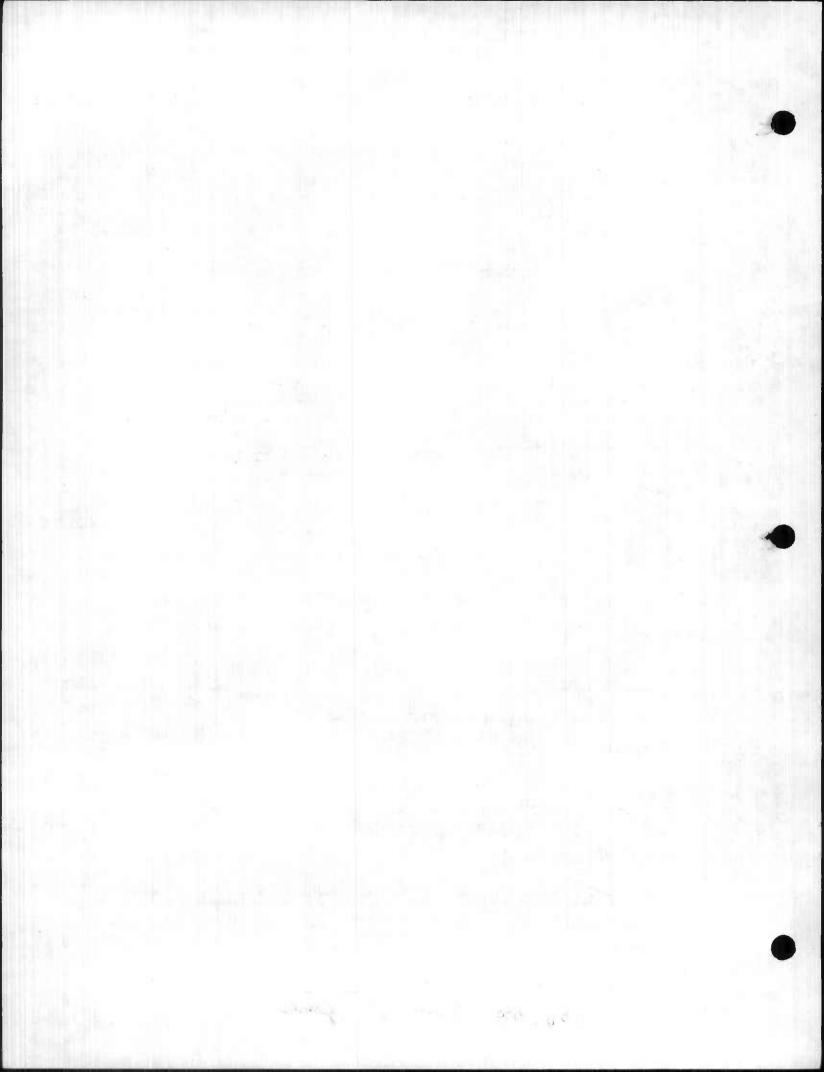
1XX purial 2 Cremetion 3 Removel from State 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 8/30/99 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical End stoige renal disease Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. physicien s the buriel Physician/Medical Due to (or es a consequence of): 88 OSO Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease þ 2 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peed anemia completion of cause of deeth? has page 2 1 Yes 2 No certificate 1 □ Yes 2 □ No of Vital Physician: 25. Was case referred to medical axaminer? 89 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Netural 5 Pending investigation Division or Attending death. 1 □ Yes 2 □ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier Medical completely (Check only one) within 2 g, 29b, Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year) D4037 8 30 99 30. Name end attitress of person who completed cause of death (Item 23a) (Type, Print) 90 Painters Mill Rd. Owings Mills, MD 21117 Duttarny Kapbnimo 31. Dete filed (Month, Day, Ybar) 32. Registrar's Şignature bouls

State Registrar

DHMH 16 Rev 6/95

SEP 0 1 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene Robert Aaron Leister Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 30, 1999 Robert Aaron Leister 4:18 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County General Hospital Westminster Carroll 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months TOM 2□ F 215-42-0312 Director 56 15, 1942 Maryland Oct. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Carroll Woodbine Director 1 ☐ Yes 21 No or 28a-1 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 6430 Woodbine Rd. 21797 Items 23a United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 5 1 ☐ Yes 2ENo Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farm Hand Agricultural 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 89 Pages 1 and 2 should be nent of Health and Mental Joseph H. Leister Edna Forest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Louise M. Leister (Wife) 6430 Woodbine Rd. P.O. Box 73 Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park Sept. 2, 1999 Sykesville, MD 22. Name and Address of Facility
Burrier-Queen Funeral Directors, P.A. 21. Signature of Funeral Survice License 1212 West Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Due to (or as a consequence of)

Physician/Medical 080 þ Completed page 2 Be 10 funeral

Examiner

The law requires that the death certificate be asscuted physician the burial signed by the a d be detached f centificate this Certification: After or Attending death. after death Director: filled in by Hospital

Records, P.O.

Box 68760.

of Vital Division 24 hours completely Within 2 To the 4

DHMH 16 Rev 6/95

State Registra

29b, Signat

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 XYes 2 □ No

25. Was case referred to medical examiner? 27. Manner of Death Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide 29a. Certifier

Hospitat: 1 Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2X ER/Outpatient 3□ DOA 28b. Time of

Due to (or as a consequence of):

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year) August 31, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death?

1 Yea 2 No

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

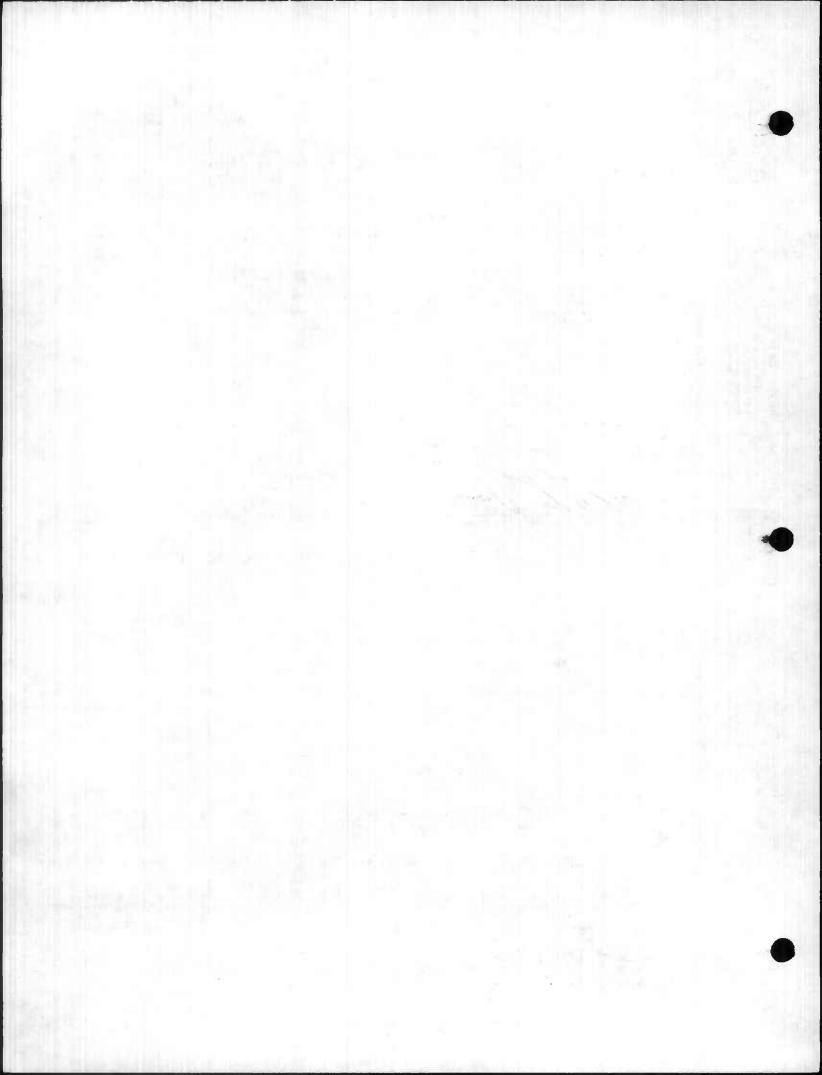
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WUCE MO 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

SEP 0 1 1999



Please Type or Print in Black Indelible ink Assure All Copies Are Legible

B.K.S LARRY McSHI	TNE	State of Maryland	/ Department of Certificate o			eneg 9	273	98	
Physician /Medical	1. Decedent's Neme (First, Middle,	LEE MC SH			2. Dete of Deeth Month	Dey 24, 19	Year	ime of Death	
Examiner	4a Facility Name (If not institution, JOHNS HOPKINS			BALTIMO	or Location of Death Ac. County of Death ORE				
Funeral Director	218-82-4216	Sex 7. Age (In yrs. last	t birthday) If Under 1 Yes Months Dey		8. Dele of Birth (Month, Day, Y	(ear) 93	9. Birthplece (Scountry) MAKY	State or Foreig	
Maryland H show fied at	Usual Residence of Decedent 10a. State 10b. County	1	own or Location					side City Limits	
th with the Min 23s or 28s-f s at be notified al Director		Aus	10f. Zip Code	218	100	. Citizen of V	What Country?		
020 ors after death v ati, or hams 23 Examinat, must by Funeral	11. Meritel Status Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Co	of Hispanic Origin? (Si uban, Mexican, Puerto to Specify:	pecify Yes or No- p Rican, etc.)		e - American Ind ck, White, etc.	ian,	
1 21215-0020 sed within 72 hours at yglens. Yglens 'ratural', or it, the Medical Exam Completed by I	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education 1 prade completed) College (1-4or 5+)	6a. Decedent's Usuel Occ (Give kind of work don life. DO NOT use reti	ne during most of wor ired)	king 16	ib. Kind of Bu	usiness/Industry	48	
de best of covered of Be	17. Father's Nemer (First, Middle, La	Mc SHINE			ne (First, Middle, Ma	iden Sumem	99)		
fimore, Mary Pages 1 and 2 show ment of Health and M ant if them 27 is ment kny or other traumed T	19e. Informent's Neme/Relationship 20a. Method of Disposition 18 Surial 2 Cremetion 3 4 Donation 5 Other (Spe	Removel from Stele	19b. Meiling Address (Stre 2923 Kill e of Disposition (Neme of etery, cremetory or other p	K AVE	Balt121 9-1-99	C. Location -	City or Town, SI	48	
Ball parmit Depart Import any in	21. Signeture of Funeral Service Lie	ensee	22. Name and Add	dress of Fecility O	to pur Ran	70	epii F	~.	
Physician /Medical Examiner	23a. Perf. Enter the disease, or or shock, or heert failure. List or Immediate Cause (Final disease or condition resulting in deeth)	. Hunshot Wo		lying, such es cardied	or respiretory arres	t,	Appro	oximate vel Between at end Death	
60, be executed idean and bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequence of):						
687 licate phys is the	Cause (Disease or Injury that initiated events resulting In deeth) Last	C. Due to (or es	e consequence of):						
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aw requires as been sign 2 should be					24a. Wes en parforme	autopsy ed?	available	on of cause	
= F # Z O	25. Was case referred to medical			26. Place of Dea	1 Deves	2 🗆 No	1 X Yes	2 No	
of Vita Physician: this certific al director, To Be (examiner? XXX Yes 2 No Hospital: 1 Inpatient 2XX ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify House) 284 Describe how injury occurred.								

To the Mospital or Attending Ptwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

1 Neturel 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 Could not be determined

(Month, Day Year) 8/24/99 2300 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

lect shot

281. Location (Street and Number or Rural Route Number, City or Town, State) 1600 Blk Aldison St. Bullinwry, Md 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner as stated.

XX Medical Examiner: On the best of examinetion and/or investigation, for my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture and little of certifier

29c. License number O.C.M.E 29d. Date signed (Month, Dey, Year) AUG. 25, 1999

eted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh

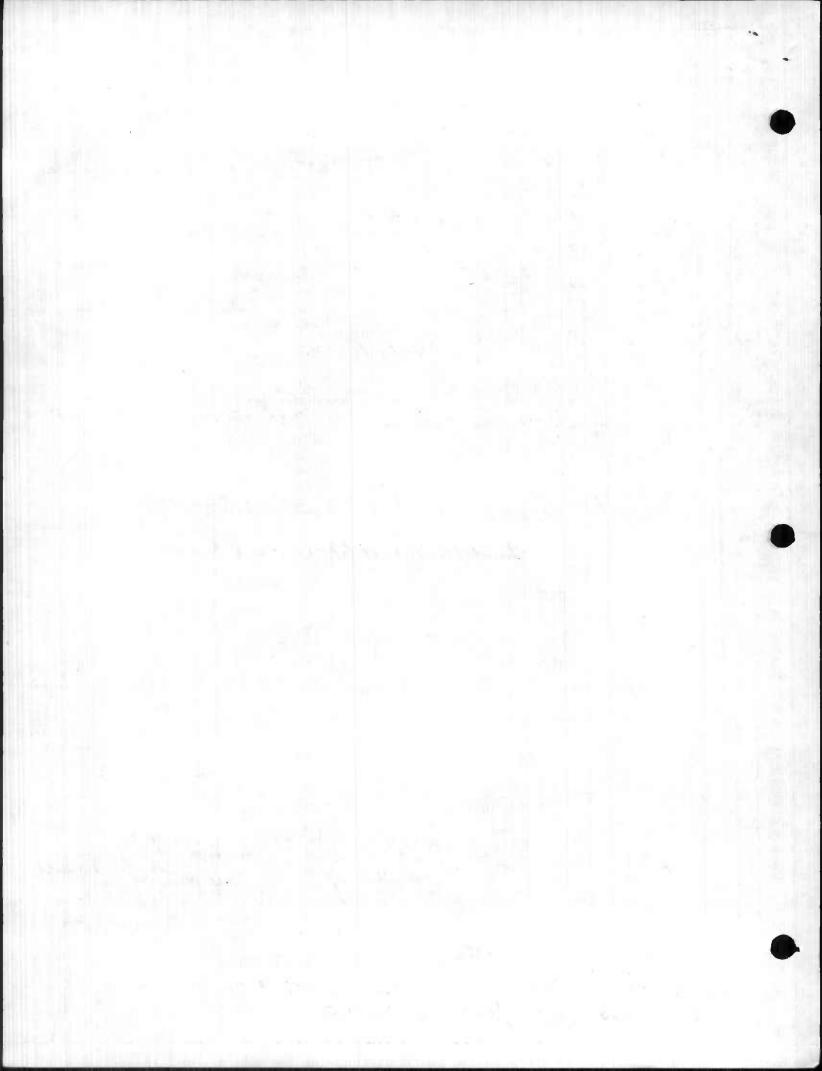
Dennis J-31. Dete filed (Month, Day, Year) nte no 111 Penn Street, Baltimore, Maryland 21201

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32 Pegistrer's Signature

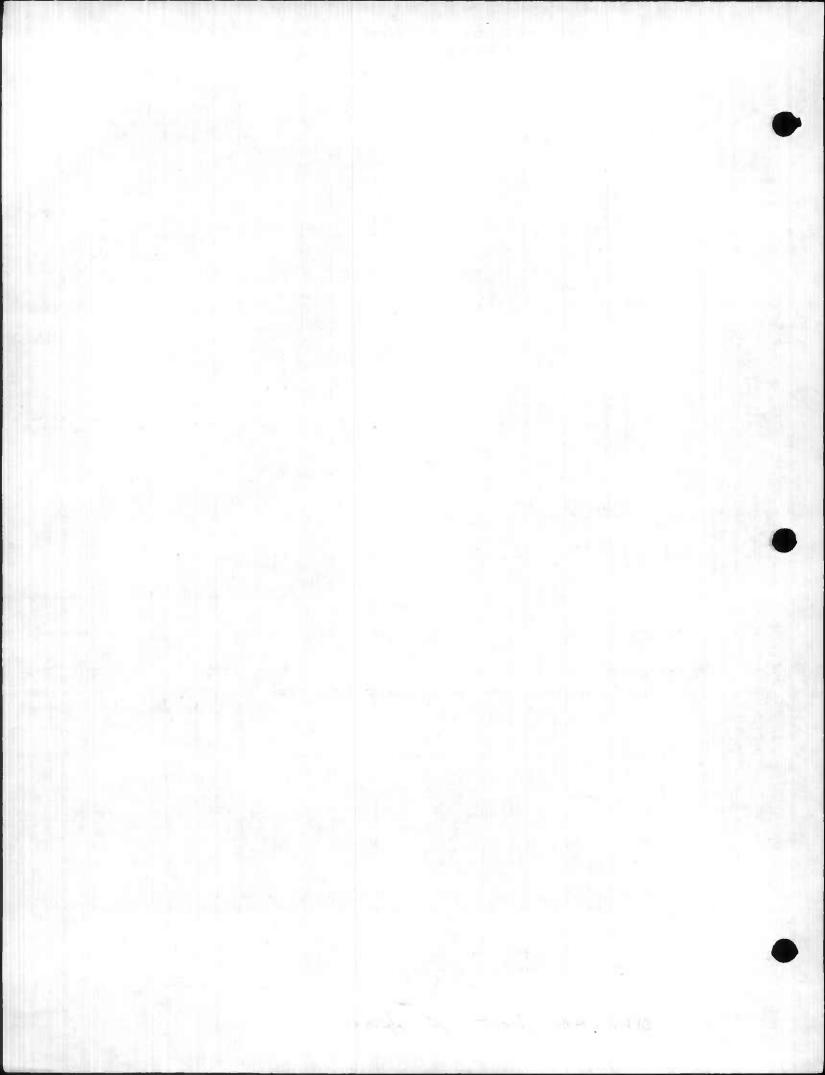
State Registrar

Medical Certification



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Ä	Examine		4a Facility Name (/							4	4b. City, Town, or I		h 4c. Count	y of Death	
					ALLEY DF						OWINGS			IMORE	
ı	Funeral Director		5. Social Security N 213–48	-4001	6. Sex 1 XM 2 ☐ F	7. Age	(In yrs. 48	last birthday) Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di DEC • 5	1950	9. Birthp	place (State or Foreign htry) MD
	ter death with the Maryland thems 23e or 28e-f show the mast be notified at	_	Usual Residence of 10a. State	10b. County			10c. Ci	y, Town or Lo	cation			31.5		1	10d. Inside City Limits 1 ☐ Yes 2X No
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on of	Attending Physicien: The I octor: After this certificate he by the funeral director, page		27. Manner of Death 1 Natural 2 Accident		28a. Date (Mo		/	28b. Time of Injury	-	28c. Injur Wor			how injury occu		<i>n</i>
Division	rect freed freed	Certification	3 Suicide 4 Hornicide	6 Could no determin	ed 288. Plac	e of Inju ding, etc.	ry - At h (Specif	ome, farm, str	eet, facto	ry, office		28f. Location (City or To	(Street and Num wn, State)	ber or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in	ecical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	caminer: On the	e best of basis of nner start	examina	wledge, death tion and/or inv	occurred vestigation	at the tir n, in my o	ne, date and place pinion, death occu	, and due to the med at the time,	cause(s) and m date and place	anner as s , and due to	itated. o the ceuse(s)
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	12	1	30. Name and addle	ess of person w	ho completed can	ise of de	ath (Iten	n 23a) (Type	Print)		-				1.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death **Physician** AUGUST 1999 9:32 AM · /Medical City, Town, or Location of Death 4c. County of Deatl Examiner If Under 1 Year | If Under 24 Hrs. place (State or Foreign . Age (In yrs. last birthday) **Funeral** 10M 20 F Months Days Hours Yrs. **Director** Usual Residence of Decedent with the Marylene 10d. Inside Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Medical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of Whet Country? 10f. Zip Code SH Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or Ite 2 No 1 Never Married 2 Married 1□ Yes 21 No altimore, Maryland 21215-0020 Specify: by If Yes, Give Yeer or Detes: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ne (First Middle, Maiden Surname) Be WIFE 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete any injury c 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee , men 23a Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 2 4 125 ONGESTIVE HEMIT Examiner Due to (or as a consequence of): Physician/Medical Examiner CARD 10 MMO PATHY LATED 15CHCMIC nding physicien and use as the buriel-trensit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, YOCANDIM Due to (or es e consequence of): ORONARY DISCHSE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NSUFFIC IENCY Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? MITRIM REGUEGITATION 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 2 ER/Outpatient Certification: To 1 Inpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours of To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 346 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 200 BAT 332 STRUET GEORGE W. MORAN BALTIMUNG 31. Date filed (Month, Day, Year) SEP 0 1 1999 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

Mc Allisma, Herson

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

10f. Zip Code

21220

7. Aga (In yrs. last birthday)

10c. City, Town or Location Middle River

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death August 28, 1999 8:40 a.m. Alice E. Malson 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min.

Days

Bel Air

Physician /Medical Examiner

Mariner Health Care

10b. County

509 Middle River Road

Baltimore

1 M 200F

5. Social Security Number

232-03-2125

Maryland

10a. Street and Number

10a. Stete

Director

Usual Rasidence of Decedent

Funeral Director

e notified at

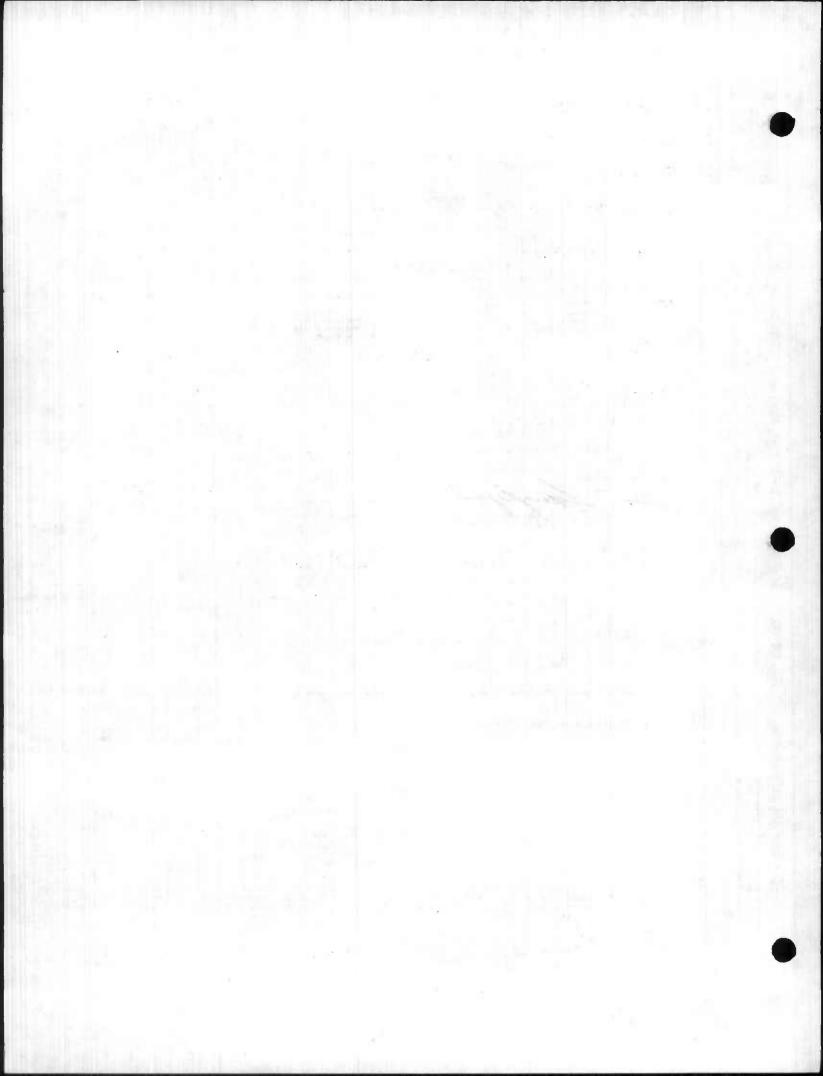
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-0020 hours after des tursif, or items at Examiner m	by Funer	11. Meritel Stetus 1 Navar Married 2 Married XXWidowed 4 Divorced	12. Was Decedent Ever Armed Forcas? 1 ☐ Yes ※XXNo If Yas, Giva Yaer or Datas:	in U,S.	If Yas,	apecify (of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No to Rican, etc.)		e - American Indian, k, Whita, etc. : white	
1215- within 72 see. than 'nat the Medic	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)		Decedent's U (Give kind of life. DO NO	work do Tuse re	one during most of wo	rking	16b. Kind of Business/Industry Own Home		
Maryland 2 d 2 should be filed th and Mental Hygis 7 is merked other traumetic event, it	To Be C	17. Father's Nama (First, Middle, Lest) Shannon C. Minor		110	use wii		18. Mother's Nat Evaline	ne (First, Middle,	, Maiden Surnam		
a de la		19a. Informant's Name/Reletionship (Type, Print)	198	. Mailing Add	ress (St	reet and Number or R	ırai Route Numb	er, City or Town,	State, Zip Code)	
C 5 N L		Susan Ryland (dau	ighter)	8	18 Hi	ah 1	Plain Dr	Bel A	ir. Md	. 21014	
altimore, mit. Pages 1 a partment of Hea portant: if them y Injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removel from Stata	Ob. Place o	Disposition (Name o	placel	Date	20c. Location -	City or Town, State re, Marylar	
Balt permit Depart importa		21. Signature of Funerel Service Licer 23. Pert1. Enter the disease, or com shock, or heart feilura. List only	undquek	death. Do	1407	Bru	ddress of Facility Zdzinski F Eastern A dying, such as cardia	venue. I	Essex. M	aryland 212	
Physician /Medica Examine	r	shock, or heart feilura. List only Immediata Causa (Final diaeasa or condition rasulting in death)	a. Come	stive	consequence	ROV	t tail	re	6	Interval Betw Onset and D	
. Box 68760, death certificate be executed e attending physician and of or use as the bunal-transit	Physician/Medical Examiner	Sequentielly list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in deeth) Last	c	/	consequence		lure			W (This	
P.O.	by Physici	Part II. Other algoriticant conditions of	Renal F	1		ng cause	a given in Part I.			atribute to the cause of	
requir	Completed								an autopsy ormed?	24b. Were autopsy fir available prior to completion of ca of death?	
	E							10	Yes 2 Kino	1 Yes 2 1	
Vital Inclan: The certificate	Bec	25. Was casa referred to medical					26. Place of De	ath (Check only	one)		
Of VIta Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2000No	Hospital:	2∏EB/0₁	stratient 3	DOA	0.1		dence 6 Oth	er (Snarih)	
DIVISION Of VITA or Attanding Physician: after death. Director: After this certific d in by the funeral director,	fication: T	27. Mannar of Death **Danual 5 Panding 2 Accident Invastigation	28a. Dete of Injury (Month, Day Ye		Tima of Injury	28c. I	Injury at Work? 1 Yes 2 No	Y	how injury occurr		
	Certific	3 Suicide 6 Could not be datarmined				ctory, off	ice	281. Location (City or To	tion (Street and Number or Rural Route Number Town, State)		
DIVI To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in by	edical		ysician: To the best of my niner: On the basis of axa and mennar atated.								
of the the	ž	29b. Signature and title of certifier				29c. Lic	ense number		29d. Date signed	d (Month, Day, Year)	
		· Nu				D19	583		August 2	8, 1999	
		30. Nama and address of person who a Manuel M. Lazat	in, M.D., 8			Abe	erdeen, Mar	yland 2	1001		

Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct. 26, 1913 West Virginia 10d. Inside City Limits 1 ☐ Yes 2XXIIIo 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white b. Kind of Business/Industry Own Home iden Sumame) city or Town, State, Zip Code) r, Md. 21014 c. Location - City or Town, State altimore, Maryland ne, P.A. sex, Maryland 21221 Approximate Interval Between Onset and Death cco use contribute to the cause of death? 2016 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? utopsy 2 KD00 1 Yes 2 No e 6 Other (Specify) injury occurred et and Number or Rural Route Number, State)

State Registrar

31. Data filed (Month, Day, Year) SEP 0 1 1999 32. Registrer's Signatura



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State of Maryland / Department of Health and Mental Hygiene

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	Funeral		5. Sociel Security Number	6. Sex		ge (In yrs. last	**	If Unde	1 Year Devs	If Under Hours	24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birth	plece (Stete or i	Foreign	
	Director		215-34-5928 Usuel Residence of Decedent	1∭ M 2	!U F	63	Yrs.	Nontri	50,5	7,00,0	A	oril 19	1936	Owin	igs Mil	ls, l	
	with the Marylan a or 28e-f show be notified at	Director	10a. Stete 10b. Count Md N/A 10e. Street and Number	•		10c. City, T	own or Lo	re	Code				10d. Inside City 1 N Yes 2				
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	tor death w flores 23a foot must 3	era	2611 Garret		as Deceden	Ever in U.S.	13.1		1218		gin? (Spe	cify Yes or No-	U.S.		an Indien,		
020	5 5 6	by Funeral	1 Never Merried 2 Me 3 Widowed 4 Divorce	rried 1 [med Forces Yes 201 Yes, Give er or Detes:	? [No		lf Yes, spe 1 ☐ Yes		an, Mexican Specify:	n, Puerto I	cify Yes or No- Rican, etc.)		eck, White, etc.			
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Maryland 21215-0020	within one. them h	Completed	(Specify only high: Elementery/Secondery (0-12)		ollege (1-4or	5+)	life.	N/	se retire	during mosi d)	t of workii	ng	N/A				
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	and eatth n 27		Catherine Mill	er - s:	ister					ers L	ane	Owings			21117		
Baltimore,	Pages 1 nent of H unt: If Nen ury or ott		20e. Method of Disposition 1 Duriel 2 Cremetion 4 Donetion 5 Other (3 □Remove Specify)	el from Stete		etary, cres	matory or o	ther ple	- 1	g. 3	Date 0, 1999	20c. Location - Balti				
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Records,		Completed by	Thrombocy	topenio	1							24a. Was a perform		ev	era autopsy fin ailabla prior to impletion of cau daath?		
	The lew ate has page 2	E	/									188	as 2 No		Yes 2DN	lo	
Vital	certificate rector, pag	20	25. Was case raferred to medical	a1						26. Place	of Deeth	(Check only or					
	5 00	0	exeminer?	Hospite	l: 1 🗆 Inpati	ient 2⊠ER/	/Outpatier	1t 3□ D	OA Ott	ner:		ne 5 Reside		er (Specia	(y)		
ion of	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		27. Mennar of Deeth 1 Neturel 5 Pendinvest		Dete of Injui		b. Time of Injury	f i	28c. Inju Wo 1 □	ry et rk? I Yes 2 □		28d. Describe h	ow injury occur	red			
Division	after death Director: , d in by the	Certification:	3 ☐ Suicide 6 ☐ Could daten	not be nined 28e		ijury - At home fc. (Specify)	, farm, str	reet, fector	y, office		-	28f. Location (Si City or Town		ber or Run	el Route Numbe	91,	
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1	Wit		30. Name and addrass of person	who complate	ed causa of	daath (Item 23	a) (Type,					August 30, 1999					
1	W.		Dennis J.	Ch	ute,	10	11	1 Per	n S	treet	, Bal	timore,	Maryl	and 2	1201		
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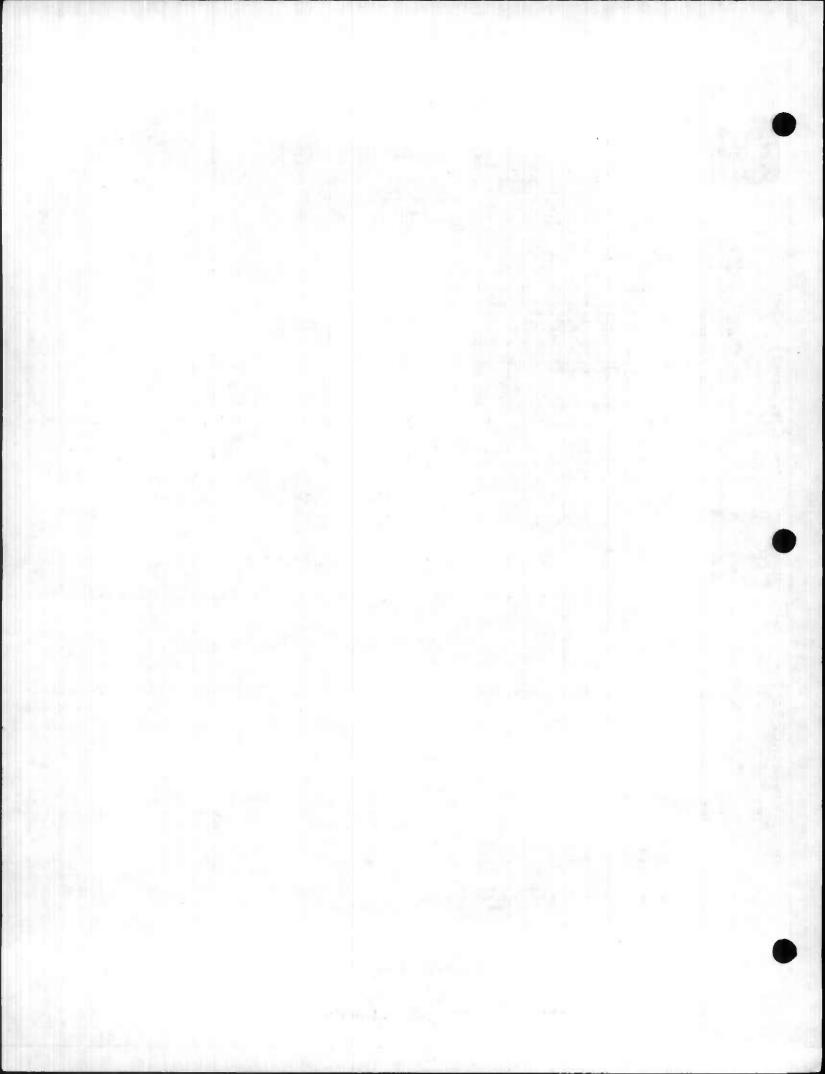
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State of Maryland / Department of Health and Mental Hygiene 99 27403

						Cen	tificate of	Death		R	eg. No.	-	1 40	V
	DI VIVI		1. Decedent's Name (First, Middle, La	st)						a of Deal		Year	3. Time of	Death
	Physicia: /Medica	_		Rita M.	Marko	wski				gust		999	9:40	A.M.
	Examine	As The March 1 and						4b. City, Town, or Location of Death 4c. County of Death						
			5602 Sandy Blu	ff Way					imore		Anne	Aru	ndel	
	Funeral Director		5. Social Security Number 6. S 219 22 4765	ex 7. Age ☐ M 2⊠ F	(In yrs. last i	birthday) _ Yrs.	If Under 1 Yea Months Days		24 Hrs. 8. Dat Min. (Mc Apr	e of Birth onth, Dey, il 25	Year) 5,1929	9. Birthp Cour Ma 1	place (Stete on try) ryland	r Foreigr
pg		-	Usual Residence of Decedent 10a. State 10b. County		10c. City. To		otion						0.1 1 - 1 - 01	h . h 1 m
aryta	a p	-										'	0d. Inside Cl	
the Maryland	A STATE OF	8 -	Maryland Anne Ar	under	Balt	imore				10g. Citizen of What Country?				
diw di			10e. Street and Number 5602 Sandy Bluft	Way			10f. Zip Code	1225		U.S.			ntry?	
72 hours after de-	o al	by Fur	11. Marital Status 1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates:			/as Decedent of Yes, specify Cu ☐ Yes 2 1 No		igin? (Specify Ye n, Puarto Rican,	Rican, etc.) Black, White			en indian, elc. nite	
d 2 should be filed within 72 hours at	Sical.	Completed	15. Decedent's Education (Specify only highest gra	ducation	16	Sa. Decede	ent's Usual Occu	pation	16b. Kind of Bu			sinass/Inc	dustry	
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Man		0	I	lenry Tribu	11				Berna	dine	Heying			
2 sh	255		t9a. Informant's Name/Ralationship (Type, Print)					er or Rural Route					
D and	n 27		Michael Markows	ci / Husban			Sandy B	luff V	Vay Ba	-	ore, Ma			25
Pages 1	- T 5 5		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		ceme	tery, crem	ition (Name of atory or other pl ss Cemet		8/28		20c. Location - Baltimo			nd
permit. Pages 1 st Department of Hea	mports any inju		21. Signature of Funeral Service Licer	1500	1		Name and Add		GOII		neral			
-			23a. Part1. Enter the disease of conshock, or heart failure.	onusky	shi				ghway			Md.	21225	
eth certificate be executed	es the bur	Medic	Sequentially list conditions, if eny, leading to immediate cause. Enlar Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Dua to (or as	a consequ		1350	OPITA	CUM	CO	NCC	147	W.
deeth cer	or use	Physician		d										
the de	the	yaid	Part II. Other eignificant conditions of	ontributing to death but	not resulting	g in the un	derlying cause g	iven in Part	1. 23	3b. Did to	bacco uee co	ntribute to	the cause o	of death
that		Dy Pu								1 🗆 Y	es 2 No	3 Pro	bebly 4)X	Unknov
law requires	hes been sig	Completed							24	a. Was a perform	n aulopsy ned?	CO	ere autopsy f ailable prior to mpletion of c death?	0
Ž.	page (107								1 🗆 Ya	s 2 No	t [∃Yes 2□	No
ë.	certificate irector, pay		25. Was case referred to medical					26. Place	e of Death (Chec	k only on	a)			
Physicien:	00	9	examinar?	Hospital: 1 ☐ inpatien	t 2□ER/	Outpatient	3 DOA	ther: 4 No	ursing Home 5	Heside	nce 6 Oth	er (Specif	(y)	
B.	completely filled in by the funeral	arion:	27. Manner of Death 1 Natural 5 Pending investigation		Year) 28b	o. Time of Injury	28c. inj W M 1[uryat ork? ∐Yes 2 □		scribe ho	w Injury occur	red		
8	Director:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury M 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office								cation (St y or Town	reet and Numb n, State)	er or Rura	al Routa Num	ber,
e Hospital	the Funeral		29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of a and manner state	examination i	lge, death and/or inve	occurred at the estigation, in my	time, date ar opinion, daa	nd place, and du ath occurred at th	to tha ca a tima, da	ause(s) and ma ata and place,	nnar as s and dua to	tated. o tha causa(s	;)
To the	dwo	29b. Signature any title of certifie 29c. License number									9d. Date signe			
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	6		20 North and address of account	ampleted course of the	ath (lag = 00	·) (Tr== 5	(V)	-10	28		. 0	77	•	
	State Registrar	9	30. Name and address of person who TO 1+1/2. S (+++++++++++++++++++++++++++++++++++	VERS	7.0)	SIS C		38	MITH	100	10%	210	90



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 4ugust **Physician** 1016 26 Mad 90 /Medical 4e Fecility Neme (If not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of De Examiner Baltimore renera arylana 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthpleca (State or Foreign Country) 6 Sax **Funeral** Months 1 M 2 4 Deys Hours 7066 Director amaica Usuel Residence of Decedent 10a Stete 10b. County 2 should be interested and Market States and Mental Hygiene. 7 is marked other than "natural", or flams 23s or 28s-f show the market other than "natural to word, the Medical Evanines must be notified at 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No Director Himare 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) rogers 401. Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Rece 11. Meritel Status American Indian, Black White etc. 1 Never Merried 2 Married 1□ Yes 20 No Specify: Black by 3 12 Widowed 4 □ Divorced Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coliege (1-4or 5+) 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be enne avid Drawi 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Flural Route Number, City or Town, Stete, Zip Code) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Important: If item 27 is any injury or other tra once. Health Md. Daltimore Der 20c. Location - City or Town, Stete 20e. Method of Disposition Dete o 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) KesVI 21 Signature of Funeral Service Licenses 22 Neme end Address of Fegility uneral Balto. Md ,21216 Enter the alseese, or complications that caused the death. Do not or heart fadure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): ettending physician for use es the buria Physician/Medicai Due to (or es e consequenca of) 23b. Did tobacco use contributs to the cause of death? been signed by the should be deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed performed' ete hes 1∏ Yes 2 1 No t□ Yes 2□ No certificete director. Be 25. Wes case referred to-medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) funeral 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

the Meryland

death with

filed withIn 72 hours efter

Pages 1 and 2 should be

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the

> State Registrar

Medicai

29a. Certifier

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Dey, Year) 29c. License number

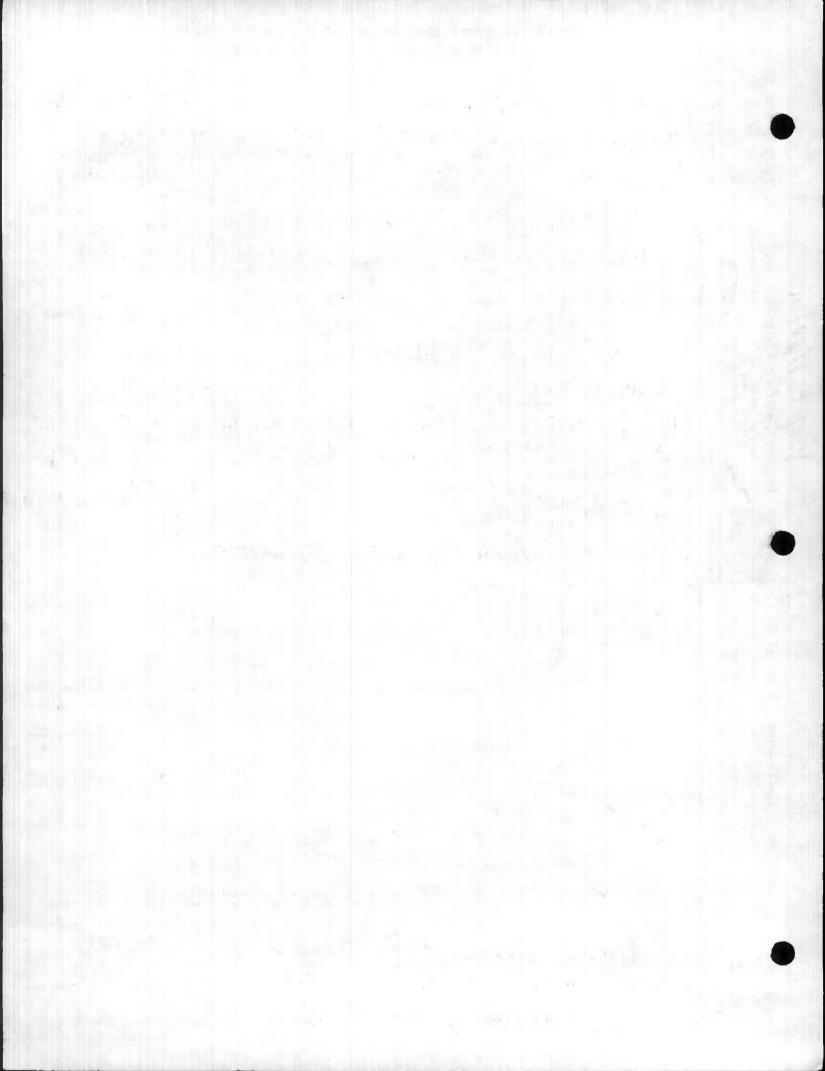
rson who completed cause of deeth (Item, 23e) (Type, Print)

aryland General Hos

31. Dete filed (Month, Dey, Year)

29b. Signeture end title of certifier

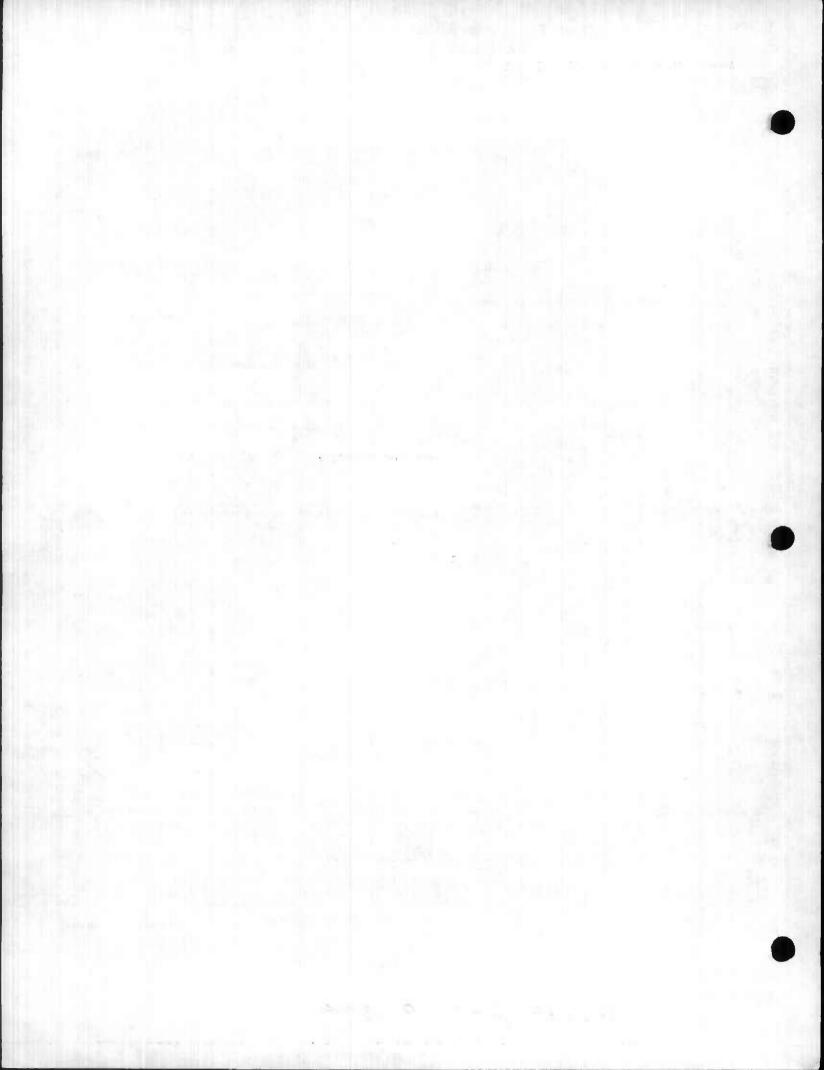
32. Registrar's Signeture



99-4867-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. MICHAEL A. McNEAL JR. State of Maryland / Department of Health and Mental Hygiene ASP Amended Item#20b perFH G775 9/2/99 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death **Physician** hae 19 1999 AUGUST 2330 /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner EITING ST. BALTIMORE If Under 1 Yaer Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country)
 D 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 10 M 2□ F Months Days 212-98-7343 Usual Rasidance of Decedant Yrs. Director the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or flams 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 242 USA Funeral 14. Race · American Indian, Black, White, etc. . Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
mt: if item 27 ie marked other than "natural", or ite 1 Nevar Married 2 Merried 1 Yes 2 No altimore, Maryland 21215-0020 1 ☐ Yas 2 1 No Specify: lf Yas, Giva Yaar or Datas: American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If Nem 27 is marked other the eny Injury or other treurmatic event, the BRIGE. Worked 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be A/15a MC rau 2 hae 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street Balto. Md. Alisa 242 21217 MS. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Dala 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Greenmount Crematory 18/26/99 Balto., Md 21. Signature of Funeral Service Licens 22 Name and Address of Facility
JOSEPH L. RUSS uneral 2222 W. north ave, 21216 23a. Part Enter the disaasa, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediete Causa (Final diseesa or condition rasulting In deeth) Bronchial Asthma Examiner Dua to (or es e consequence of) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Due to (or es a consequence of): 68760 Physician/Medical å Dua to (or as a consequence of) Box P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of geeth? Ĕ 1 Yee 2 No 3 Probably 4 Unknown signed d be dar Records. Aq 24b. Were eutopsy findings evallable prior to Completed 24a. Was an autopsy performed? completion of causa of death? 12 Yes 2 No 2 □ No 1 Yes certificate of Vital 86 25. Was case rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 X Yas 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 1 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred * Houpital or An.
Fours after death.

* Director: After

* by the fv Attac Division Attending 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Placa of Injury · At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature end title of certifian AUGUST 20, 1999 O.C.M.E 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) nes 111 Penn Street, Baltimore, Maryland 21201 O 32. Registrar's Signature 31. Date filed (Month, Day, Year) State souks SEP 0 1 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Year **Physician** 9:02 AM AUGUST Kimberly Marie Maccubbin 1999 29 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 10 M 20 F 218-15-2473 25 Director 03/02/1974 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits worle filed within 72 hours after death with the Marylas Hygiene. Wher than "natural", or frems 23s or 28s-f show ent, the Modical Example martle inclined so 1 ☐ Yes 2 No Director Baltimore **Baltimore** 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 3A Mopec Circle 21236 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Micheal's Arts & Crafts Department Manager 17. Father's Name (First, Middle, Last) marked other 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Itam 27 is marked oth jury or other treumatic even Be Milton Richard Maccubbin Jean Marie White 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Jean Maccubbin 3 A Mopec Circle Baltimore, Maryland 21236 20e. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetery or other place) Date 20c. Location - City or Town, State Burlet 2 Cremation 3 Removel from State permit. Page Department of Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 9/2/99 Baltimore, Maryland
Dippel Funeral Home Inc. 21. Signature of Funeral Segrice Lice 7110 Belair road Baltimore, Maryland 21206 Approximate and limited the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final percalcemia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner idney te certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) ovarian cancer Physician/Medical Due to (or as e consequenca of) as attending 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy Completed peen: performed' certificate has t 1 Yes 2 □ No 1 ☐ Yes 2 K No director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending After 5 Pending investigation 1 X Natural 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edical 29a, Certifier 1E Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

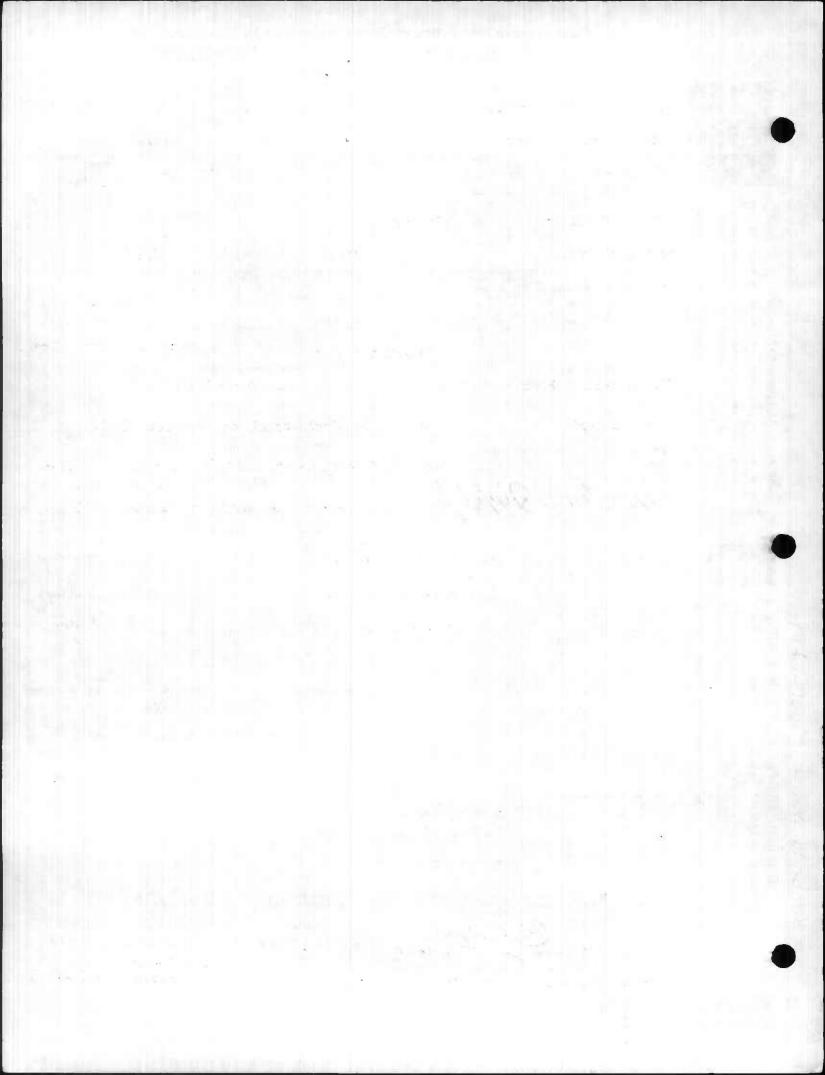
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 4 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier AolChabboz August 29, AT 2438946 year resident second 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) ANTOVN KHABISA = M.D HUSPITAL, 201 EAST UNIV. PARKWAY, BALTIMOREMD 21218

State Registrar MEMORIAL

31. Date filed (Month, Dey, Year) SEP 0 1

32. Registrar's Signature

Kimberly Marie Maccubbin



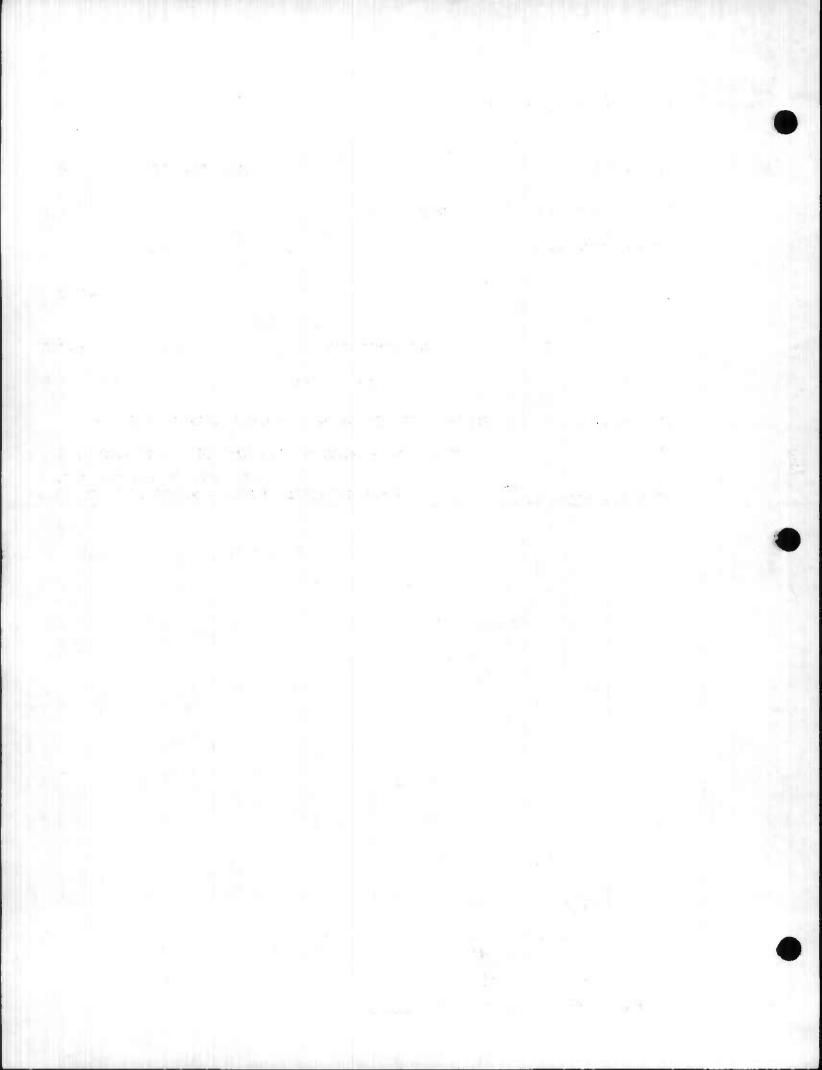
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Weinstein Novin 1999 0950. AUGUST 20 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOSPING OF BALTIMORR J:NA: BALTIMORE N/A If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) MAR 21, 1913 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Months Deys Yrs. Director 246-46-8322 86 Usual Residence of Decedent with the Maryland 10a State Show 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD BALTIMORE RANDALLSTOWN 1 ☐ Yes 2X No Director 289-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3725 LAMOINE ROAD 21133 U.S.A. Funeral Herns 14. Race - American Indian, Black, White, etc. 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married ò 5-0020 1 ☐ Yes 2X No Specify: WHITE by 3X Widowed 4 ☐ Divorcad natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) MilyRes Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 **ADMINISTRATOR** FEDERAL GOVERNMENT other Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Mentai end Mental 2 NATHAN WEINSTEIN IDA SWILLING 19a. Informent's Nema/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cobe) Department of Health e important: if item 27 is any injury or other tra 3725 LAMOINE ROAD - RANDALLSTOWN, MD 21133 DOROTHY KESLINGER / DAUGHTER 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAK PARK 8/31/99 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licansee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediete Ceuse (Final diseese or condition resulting in death) MYOCARDIAL INFARCTION #2 **Examiner** Due to (or es a consequence of): Examiner REPTIC SHOCK Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760. TERIONITIS nding physician the death certificate be Physician/Medicai that initiated events resulting in death) Last Due to (or es e consequença of) 8 ERFORMED DIVERTICULIAI P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown The law requires that of Vital Records. by 24b. Were eutopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of death? 1 Yes 2 Pin 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how Injury occurred After 1 Naturel 5 Pending Investigation Division Attending death. 1 Yes 2 No 2 Accident efter death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ICES 0000 30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print) SIND! HOSPITA OF BOLTIMORE EDVORDO Cin 32. Registrar's Signature 1 1999

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month 4b. City, Town, or Location of Deeth 3/31 1999 Jay Wilbur Naylor 4a Facility Name (If not institution, give street and number) 4c. County of Death Levindale Hebrew Geriatric Center & Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Dec. 22, 1930 9. Birthplace (Stete or Fore Country) Pennsylvania 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months XXM 2□F 195-22-4052 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Essex 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 1101 Foxwood Lane 21221 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Black, Whita, etc. NOYes 2□No Korean NYes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 20€No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Inspector Steel Mill 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Naylor Beatrice Hawn 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1101 Foxwood Lane, Baltimore, Maryland 21221 Joanne L. Naylor (wife) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Mem. Gardens 9/3/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Füberal Service Licensee 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Prifer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, show or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel acute cardial disease or condition resulting in death) Due to (or as a consequence of): monors Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): venti Laton depende Due to (or as a consequence of): chonic obstructure Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 20 No 1 Yes 2 No dependent non insulin 25. Was case reterred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1- Natural investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Box 68760 o Records, Vital Attending hours after deal ò

Physician

/Medical

Examiner

Director

Funeral

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Completed

80

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hyglene.
int: if them 27 la marked other than "natural", or items 23s or 28s-f show my or other transmit be notified allow my or other transmit be notified at my or other transmit be notified at

21215-0020

Baltimore, Maryland

permit. Page Department

Physician /Medical

Examiner

Physician/Medical

Certification:

Division

Registrar

31. Data filed (Month, Day, Year) State SEP 0 1 1999

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Fromb Mazon 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Belveden

32 Registrar's Signeture

0:44907

29c. License number

29d. Date signed (Month, Day, Year)

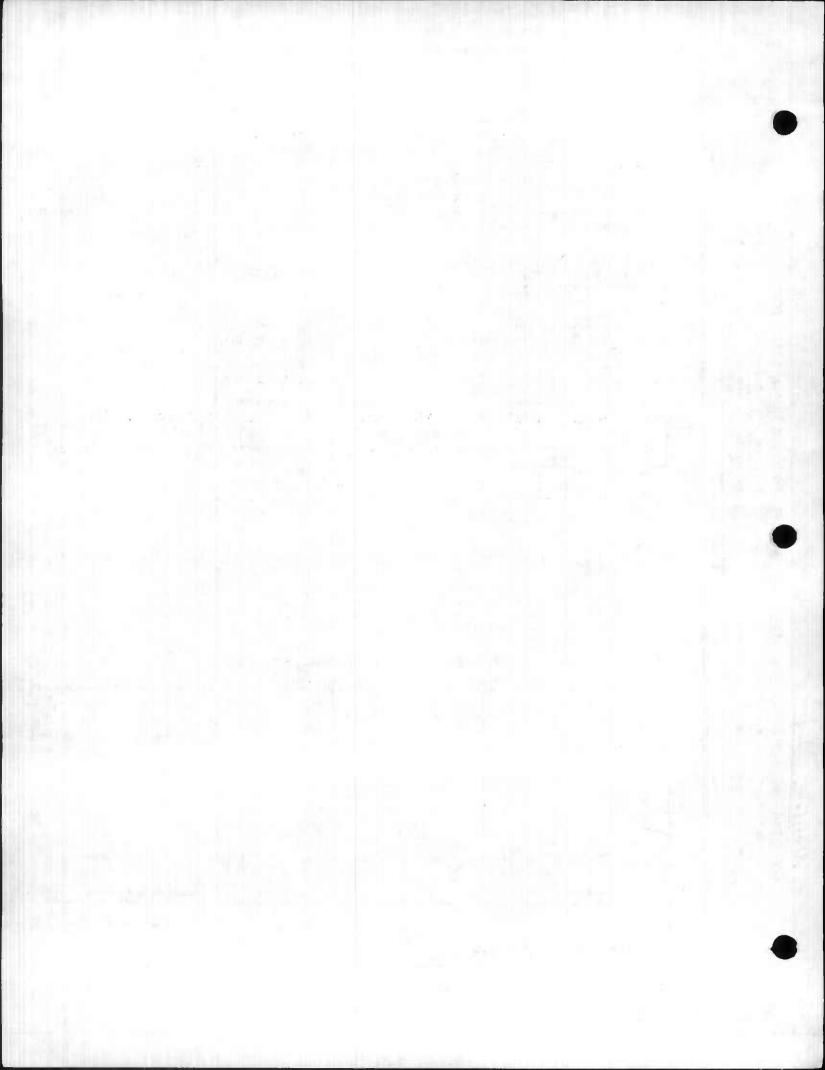
CONSUELO

12 certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated (check only one)

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

24 hours • Funeral

To the Within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 8 Atm Uliver doanne AUGUST 27 1999 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Church Home Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Dete of Birth (Month, Day, Year) Months Deys Hours 1□M XQF 247-90-0356 49 Yrs. Director Oct. 8, 1949 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Xes 2□No Director Md. n/a Baltimore 288-1 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. The following the marked other than "natural, or itema 23a or in influy or other traumatic event, the Medical Experiment mast han any influry or other traumatic event, the Medical Experiment mast han 742 N. Linwood Avenue 21205 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indian, Black, White, etc. 1. Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No · Specify: Black Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DLLR Typist-Clerk 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 80 Robert Oliver Lue Ida Ragin 0 19e. Informent's Neme/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Vertrell Oliver 104 N. Curley Street Baltimore, Md. 21224 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removal from Stete Liberty Hill Cemetery Sept. 4 Summerton, SC 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service Licensee 8. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical remong of Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical the Due to (or es e consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown é 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Wes an autopsy 1 ☐ Yes & No 1 🗆 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury NA 28d. Describe how injury occurred 28c. Injury et Work? Neturel 5 Pending investigetion NA NA 1 Yes 2 No NA 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide NA NA 29e. Certifier Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner as stated.

The law requires that the death certificate be axecuted Box 68760. P.O. of Vital Records. certificate Physician: this Division or Attending 24 hours after death.

Funeral Director: A Hospital

Maryland 2

Baltimore,

completely within 2 To the ş 0

DHMH 16 Rev 6/95

JULIAN 31. Dete filed (Month, Dey, Year) State Registrar SEP 0 1 1999

(Check only one)

29b. Signature and fitle of certifier

CRAIG 32. Regisfrar's Signature

5000 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

CHURCH HOSPITAL

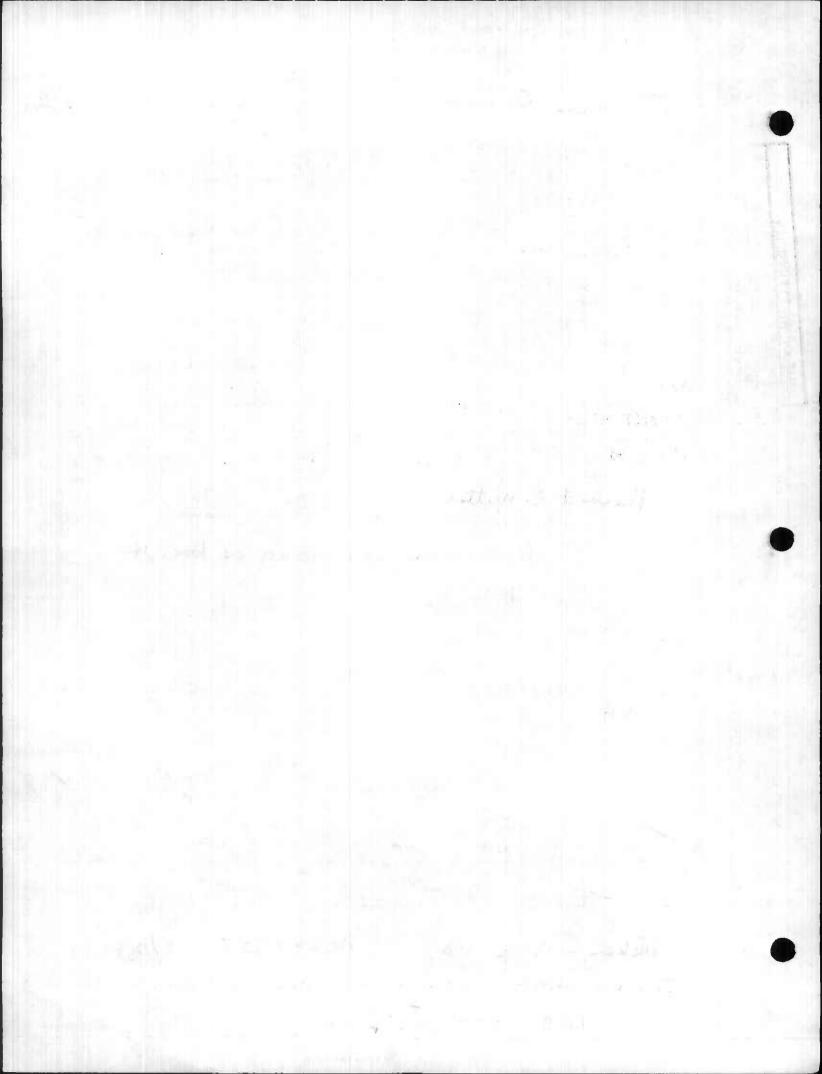
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29c. License number

ORIGINAL

S. BROADWAY

29d. Date signed (Month, Day, Year)



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			1. Decedent's Name (First, Middle, Las	t)					2. Dete of Dec	eth _		3. Time of Deeth	
	Physic		Marie Teresa Pugh						August	31, 1	999	3:30 AM	
	/Medi Exami		4e. Facility Neme (If not institution, give	street end number)				4b. City, Town, or L		T			
-1	w.Au(iii		Good Samaritan Nu	rsing Home	9			Baltimor	`e		N/A		
	Funeral	П	5. Social Security Number 6. Se	7. Ag		st birthday)	If Under 1 Ye	ar If Under 24 Hrs.	_	h Vanal		ce (Stete or Foreign	
e:	Director		Usuel Residence of Decedent	□M 212 F	73	Yrs.	Months De	ys Hours Min.	8. Dete of Birt (Month, De) August	17,1926	Balti	ce (Stete or Foreign imore, Md	
	deeth with the Maryland ms 23a or 28a-f ehow r must be notified at	tor	Maryland Baltimo	re Co.		Town or Lo ltimor					100	d. inside City Limits 1 ☐ Yes 2 ☐ No	
	or 28	Funeral Director	10e. Street and Number				10f. Zip Cod	6		10g. Citizen of \	Whet Country	y?	
	th with	a D	6210 Haddon Ave.				2	21212	U	nited S	tates	of Americ	
	items :	ner	11. Maritel Status	12. Wes Decedent	Ever in U.S	13.	Was Decedent	of Hispenic Origin? (Sp Juban, Mexican, Puerto			e - Americar	n Indien,	
0	or its	F	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀					Hican, etc.)			White, etc.	
02	ours Fre	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2X	No Specify:		Specify	Whi	te	
21215-0020	within 72 hours after cene. ene. than "naturel", or iten	Completed	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation le completed) College (1-4or 5	54)	16e. Deced (Give life. I	dent's Usuel Oct kind of work do DO NOT use ret	cupation ne during most of work tired)	king	16b. Kind of Br	usiness/indu	stry	
	T3 Ch 94	NO.	12	N/A	.,	(Office V	Vorker		C & P T	elepho	one Co.	
Maryland	be filed tal Hygi d other	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Meiden Sumen	10)		
la	D # D 0	To	George Joseph Bel	l Pugh				Catherin	ne Agnes	Feeley			
an	1 and 2 sh Heelth end Im 27 is m		19e. Informent's Neme/Reletionship (T	ype, Print)		19b. Meilir	ng Address (Stre	eet end Number or Ru	ral Route Numbe	r, City or Town,	Stete, Zip C	Code)	
			Mr. Francis X. Pu	gh(Brother	r)	2518	Lawnsid	de Road	Γimonium	, Maryl	and 2	21093	
ore			20a. Method of Disposition		20b. Ple	ece of Dispo	sition (Neme of netory or other)	piece)	Dete	20c. Location -	City or Town	n, Stete	
Ĕ	Page nent o int: If iry or		1 XBurial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify						9/03/199	9 Baltir	more.M	larvland	
Baltimore,	permit, Pages Depertment of P Important: If Ne eny Injury or of		21. Signeture of Funerel Servica Licans	Jeffrey				dress of Fecility Ruc 105					
		Н	23e. Pert1. Onler the disease, or comp shock, or heert failure. List only o	lications that chured		Do not ent	er the mode of o	dying, such es cardiac	or respiretory er	rest,	, A	Approximete ntervel Between	
	Physician /Medical Examiner	ner	Immediate Cause (Finel disease or condition resulting In deeth)	6			PEI					Onset end Death	
68760,	that the death certificate be executed of by the ettending physician end deteched for use es the bunel-transit	edical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest	c		es e conseq							
Вох	death certifica e ettending ph d for use es th	M		d									
	death e ette d for	icia	Pert II. Other significant conditions co	ntributing to death b	ut not result	ting in the ur	nderlylng cause	niven in Part i	23h Did t	obacco usa co	ntributa to t	he cause of death?	
s, P.O	requires that the seen signed by th hould be deteche	by Physician/M	<u> </u>	rova of	0	_ /	ress	ナ		res 2□ No	3 Probe		
Records,		Completed			/				24e. Wes o	en eutopsy med?	avelle	e eutopsy findings eble prior to pletion of cause eeth?	
8	siclen: The law certificate has b lirector, page 2 s	NO.							1 □ Y	es 2240	10	Yes 2□ No	
Vital	en: rtiflica ctor,	Be	25. Wes case referred to medical					26. Plece of Dee	th (Check only o	ne)			
5	> 00	2	exeminer?	Hospitel:	nt 2 E	R/Outpetien	t 3 DOA	Other: 4 Nursing He	ome 5 Resid	enca 6 🗆 Oth	er (Specify)		
ion of	Attending Ph or death. ector: After th by the funeral		27. Mans f of Deeth Teturel 5 Pending investigation	28e. Dete of Injui (Month, De)	ry y Year)	28b. Time of Injury	V		28d. Describe h				
Division	al or Atte s efter de ii Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Inju- building, etc	ury - At hon c. (Specify)	ne, ferm, str	eet, factory, offic	ca	28f. Location (S City or Tow	itreet end Numb n, Stete)	er or Rural F	Route Number,	
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) ertifying Phy	aicien: To the best of nar: On the besis of end manner ste	examinetic	ledge, deeth on end/or inv	occurred et the restigation, In m	time, date end plece, y opinion, deeth occur	end due to the or red et the time, o	ause(s) end ma dete end place,	end due to the	ted. he cause(s)	
	Tota With Tota	M	29b. Signeture end title of certifier	110	00	e au		94650		29d. Dete signe 8 - 3	_	ay, Year)	
			30. Name and process of person who co	oppleted cause of de	eeth (ttem :	23e) (Type,	7					rates in many	

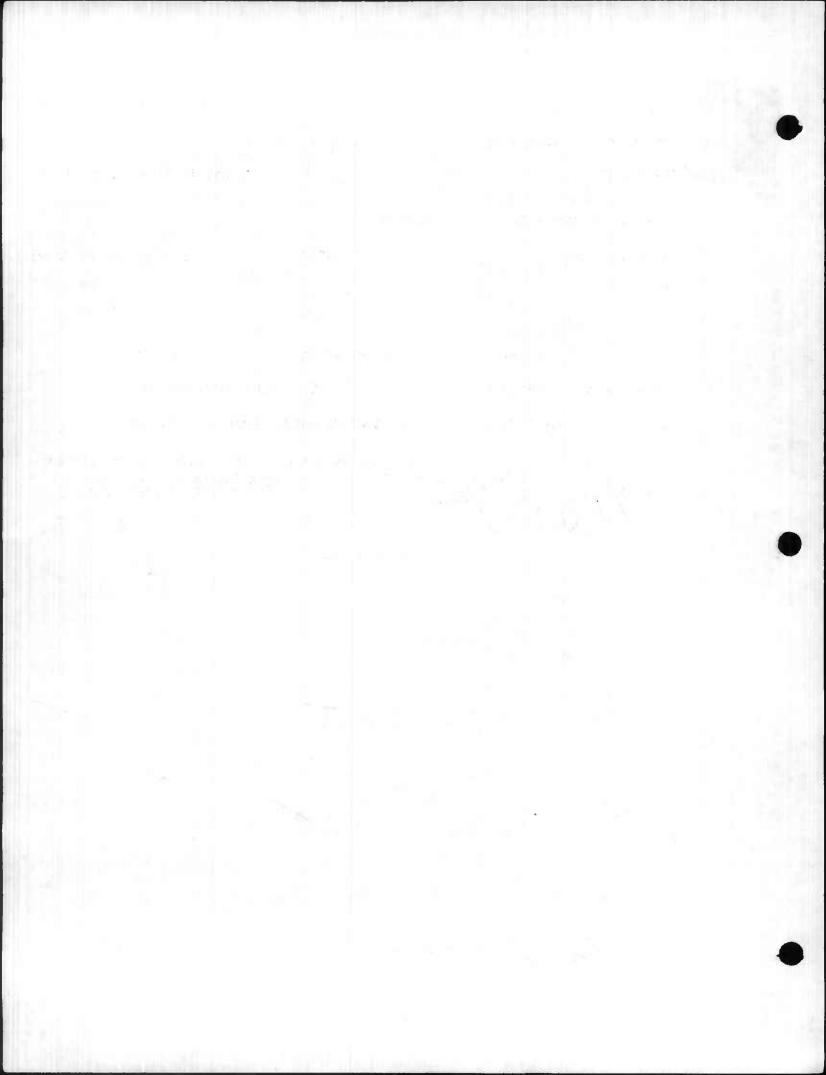
State Registrar

31. Dete filed (Month, Day, Year) SEP 0 1 1999

32. Registrer's Signeture B. Sports

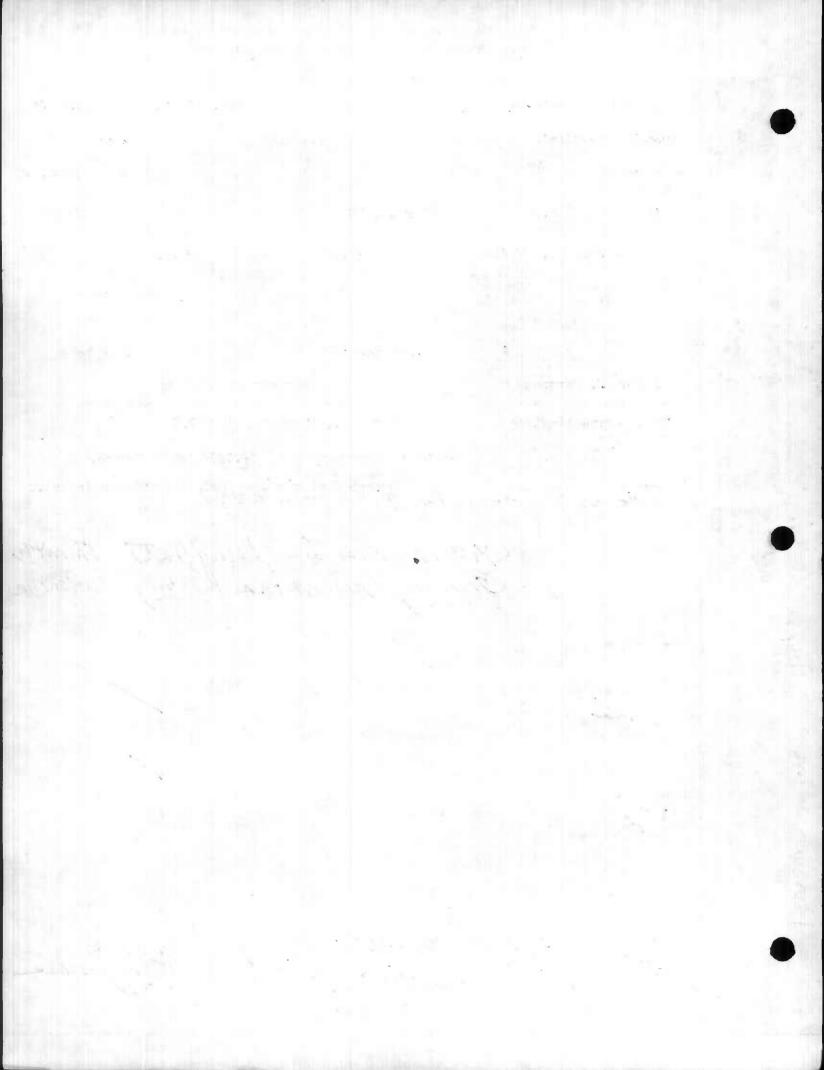
DHMH 16 Rav 6/95

Marie Pugh



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		Ċ	Certificate of	Death	Reg	. No. 99	27411			
Physician	Decedent's Neme (First, Middle, Last)				2. Dete of Death Month	Dey Ye	3. Time ot Death			
/Medical	John Earl Parsons					1999	10:44AM			
Examiner	4e Facility Neme (If not institution, give street end numbe	r)		4b. City, Town, or L.	ocation of Deeth	4c. County of D	Death			
	Suburban Hospital			Bethesda		Montgo				
Funeral Director	577-01-0680 1™ 2□ F	sge (In yrs. last birtho	Months Days		8. Dete of Birth (Month, Dey, Y) June 10,		Birthplace (Stete or Foreign Country) ashington, DC			
Pu *_	Usuel Residence of Decedent 10a, Stete 10b, County	10c. City, Town o	or Location				10d. fnside City Limits			
the Maryland 228-1 show notified at	N/A N/A	Washing				1X Yes 2 □ No				
¥ 64 0	3737 Legation St. NW #106		10f. Zip Code 20015		U	.S.A	Country?			
O2(02(11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Deceder Armed Forces 11 Yes, Give Yeer or Dates	No	13. Wes Decedent of It Yes, specify Cub1 ☐ Yes 2 IN No		pecify Yes or No- Rican, etc.)		American Indian, White, etc. White			
I 21215-0 ed within 72 ho yglene. For than "natur it, the Medical Completed	15. Decedant's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occup	pation during most of work	king 16	b. Kind of Busine	ess/Industry			
within see. then be the the	Elementary/Secondery (0-12) College (1-4or	5+)	Give kind of work done fe. DO NOT use retire							
d 21	4	Com	munications C & P Telephone							
D STATE OF	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma					
should be an americal marked imarked imarked	William H. Parsons			Marguer	etta Jack	son				
2 sho	19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code									
C T N L	Thurza Campbell-Niece		Farm Rd.,	Sherborn						
ges 1 and it of Heal II Nem 2 or other	20a. Mathod of Disposition 1 ☐ Burial 2 🛣 Cremetion 3 ☐ Removel from Stet		isposition (Neme of cremetory or other ple	ce)	Dete 20	c. Location - City	or Town, State			
altimonic Page and Page of Page 10 Pag	4 Donetion 5 Other (Specify)	Nationa	1 Cremator	y 8	3/27/99 Fa	alls Chu	rch, VA			
Baltimore, permit. Pages 1 at permit. Pages 1 at permit of Hear important: if fem any injury or other phice.	21. Signeture of Eynerel Service Licensee	0 0	Joseph Gar NW, Washin	wler's So	ns INC, 5	130 Wisc	consin Ave.			
	23a. Pert1. Enter tha diseese, or complications that cause shock, or heert tailure. List only one causa on each	ed the deeth Do not		-			Approximete			
/Medical Examiner Literature Examiner E	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury c.	uma	onsequence of):	ino m	ling	Mey	1 Month Umbnour			
O. Box 68760, the death certificate to a the attending physician had for use as the buring ysician/Medical E	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or es e con	nsequence of):							
o de e de e de e de e de e de e de e de	Pert It. Other significant conditions contributing to death	but not resulting in th	na undarlying cause gi	ven in Pert I.	23b. Did tobe	cco use contrib	ute to the cause of death?			
P at your H	Sepsies				1 Yes 2 740 3 Probably 4 U					
cord requir been a should about					24e. Wes an a performe		4b. Wara autopsy tindings available prior to completion of cause of daeth?			
I Receipt the law					1 ☐ Yes	2 00 No	1 ☐ Yes 2 ☐ No			
Vital F sicien: The certificate irector, pag o Be Co	25. Was case refigired to medical			26. Placa of Deal	th (Check only ona)					
of VI hysteti hysteti his car i direc	Hospitel: 1 Inpat	ient 2 DER/Outpu	atient 3 DOA Oth	hor	ome 5 Residence	a 6 Other /	Specify)			
	27. Menner of Death 1 Death 5 Pending (Month, D) 2 Accident investigation	ury 28b. Tim	na of 28c. tnju		28d. Describe how		process)			
DIVIS	3 Suicide 6 Could not be determined 28e. Plece of Ir	njury - At homa, ferm tc. (Specify)	, street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in Medical Cer	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	of examinetion end/o								
To the comp	29b. Signeture end-title of certifier	aster	mo (7.		Date signed (Mug. 16)	lonth, Dey, Year)			
	30. Name and addrass of person who completed cause of	death (Item 23a) (Ty	rpe, Print)	104/7 55 30 1	Wisc	des	ychuse			
State	31. Deta tiled (Month, Dey, Year) 32. Regist	rar's Signetura	6 /	,						
Registrar	SEP 0 1 1999	sure f	. spork	2		2-11				

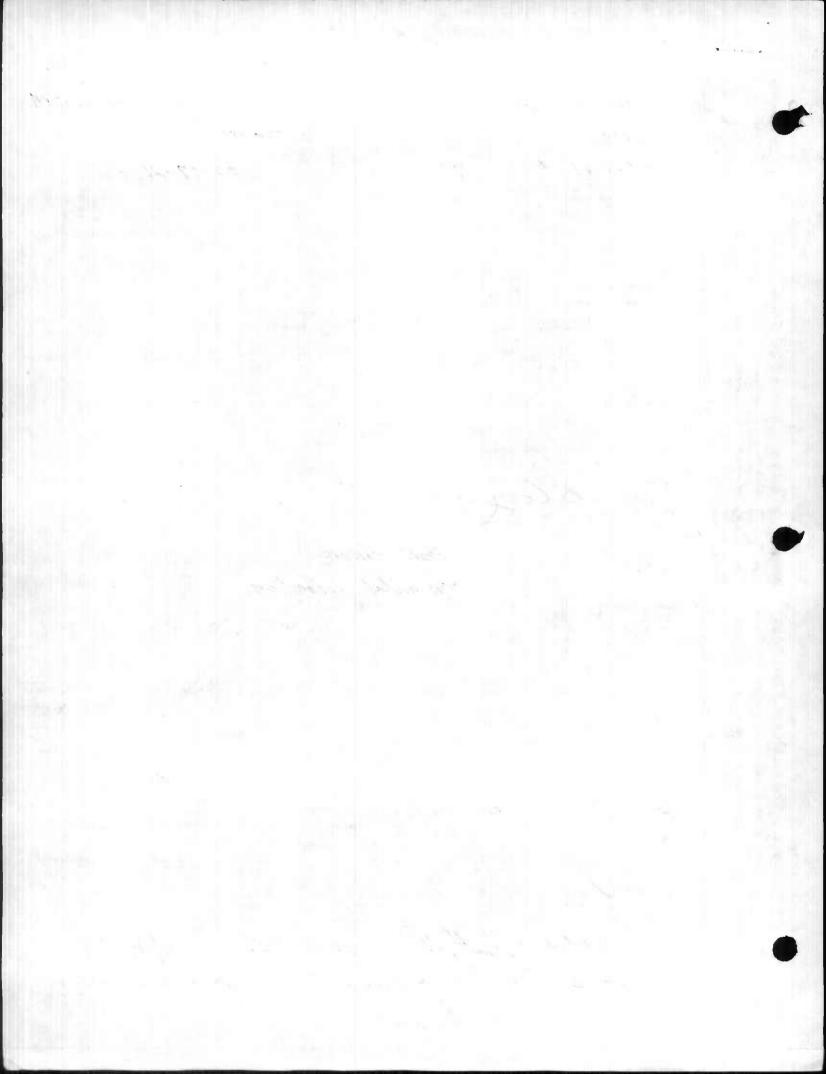


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey 28 **Physician** William 1:40 PM 08 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore UMMS If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Deys 218-10-8461 12XM 20 F 02-07-2, Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-t show Carroll Mt. Airy Maryland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23s or 2601 Gillis Road 21771 United States Funeral Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. Wher then "netural", or its 1 23 Yes 2 □ No If Yes, Give Year or Datea: WW II 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yea 2 No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MD Shipbuilding and Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Drydock Co. llth 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of Curtis S. Penn Emily R. Gosnell 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Penn 2601 Gillis Road Mt. Airy, MD Wife 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 8/31/99 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville Cemetery Taylorsville, MD 22. Name end Address of Fecility
Burrier-Queen Funeral Directors, P.A. 21. Signeture of Funeral Service Licensee over 1212 W. Old Liberty Road Winfield, MD 21784 used the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, on task line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or es a consequence of) 88n Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings aveilable prior to complation of causa ot death? Completed 24a. Was an autopsy 1 Yes 2 KNo 1 Tyes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 10 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred edical Certification: 28c. Injury et Work? 1 Netural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner es stated.

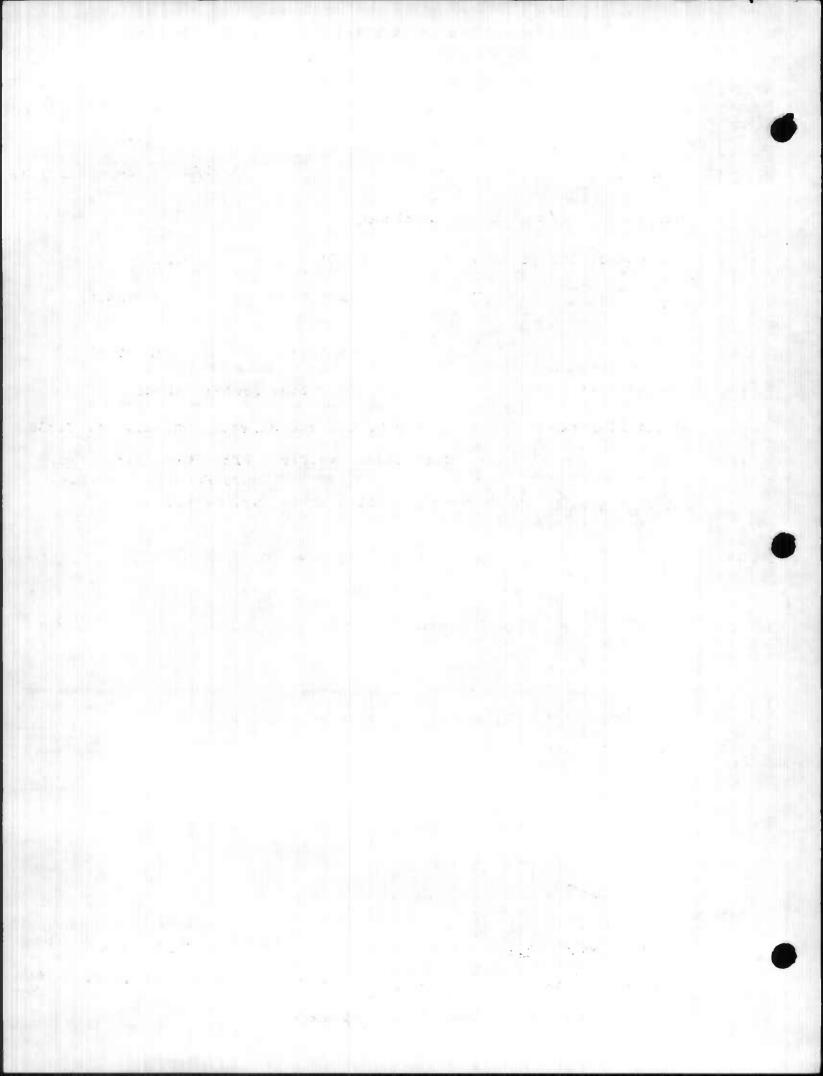
2 Medical Examiner: On the basia of examination end/or investigation, in my opinion, daeth occurred et the time, date end place, and dua to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date sighed (Month, Day, Year) 29b. Signature and title of certifier 1355869536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Greene ST. Baltimore Lamont Smith 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



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			,	Certificate of	Death	Reg.	No.	2/4/3
		1. Decedant's Nama (First, Middla, Las	0 .			2. Data of Daath Month	Day Yaar	3. Time of Death
	Physician /Medical	Elaine	Park	5			28 199	9 13:05 pm
	Examiner	4e Facility Neme (If not institution, give	street end number)		4b. City, Town, or Lo	cation of Deeth	4c. County of De	eth
		Harbor Hosp	ital Cente	7	Baltim	>10	N/A	
	Funeral	5. Sociel Security Number 6. S		Mantha Day	r If Undar 24 Hrs. B Hours Min.	8. Date of Birth Month, Day, Ye 7/20/36		irthplace (Stata or Foreign Country)
	Director	213-32-6454 Usual Rasidenca of Dacedent	□ M XC3 F 6	3 Yrs. Mornins Days	s Hours Wiff.	7/20/36	We	st Virginia
	M M	10a, Slata 10b. County	10c. Ci	ty, Town or Location				10d. tnsida City Limits
	Mary Mary to	Maryland N/A	A E	Baltimore				XIXYes 2□ No
	ter death with the Maryla items 23e or 28e-f show foet must be notified at funeral Director	10e. Street and Number		10f. Zlp Code		10g.	Citizen of Whet C	Country?
	M Sa Ch	lW. Conway Stre	ot Apt 711	2120	1	17	C	
	ther death iner must iner must Funeral	11. Meritel Status	12. Wes Decedent Ever in U	I,S. 13. Wes Decedant of	Hispanic Origin? (Spe ban, Maxican, Puerto	ecify Yes or No-	S 14. Raca - An	
0	or the	1 Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 ☑ No			Hican, atc.)	Black, Wh	
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21215-0020	ed within 72 hours ygiene. It the Medical Exi. Completed by	15. Decedant's Ed		16a. Decedent's Usual Occi	upation	16b	. Kind of Busines	s/Industry
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21	Sept.	11		Homem	aker		Own Hor	me
Pu	tal Hy d other event	17. Fathar's Nama (First, Middla, Last)			18. Mothar's Nama	(First, Middla, Maid	dan Sumama)	
la la	Mentity build by Mentity and by Ment	Wesley Aral Rus	sh		Edna Ra	chale B	rake	
Maryland	of and and	19a. tnformant's Name/Relationship (7	ity or Town, Stata,	, Zip Code)				
-	all all all all all all all all all all	Craig L. Parks		109 W. Cle	ment Str	eet. Ba	1to	Md. 21230
ore	2. 五 m 4	20a. Mathod of Disposition		109 W. C1e) Place of Disposition (Name of cametery, crametory or other pi	(aca)	Data 20c	Location - City of	or Town, Stata
Ĕ	Page ment my or	urial 2 Cramation 3 Donation 5 Other (Specify	Hamoval from Stata	en Haven Mei	m.Park 8	3/31 G1	en Bur	nie Md.
Baltimore	A Party of	21) Signatura of Funaral Sarvica Lican			rass of Facility Gor			
m	88 E 8 8	Marit	Vel.					
100		Part1. Egitar tha disaasa, or comp shocked r haart failura. List only	olications that caused the deal	th. Do not antar the moda of d	tchie Hwy	or raspiratory arrest,	· Ma .	Approximata
J	Physician	shock or haart failura. List only	one causa on each line.					Intarval Between Onsat and Death
	/Medical	Immediata Cause (Final	1. 1.	Dans of a	Cilya			12 hours
	Examiner	disease or condition rasulting in daath)	a. MCJIE	RESPITATORY	Tailore			15 10013
	<u> </u>		()	Respiratory or as a consaquanca of): obstructive	0. 1	dica		10 years
/	axecuted n end ial-transit	Sequentially list conditions	b. Dua to (or as a consequence of):	TO I MOVEL !	otise	مرو	, jewi)
ó	The law requires that the death certificate be associted ate has been signed by the attending physician and paga 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that Initiated events		estinal ble	s Indi			24 hours
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	ng ph as th	resulting in death) Last						
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	es that the death cer igned by the attendir be detached for use by Physician/A	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying cause of	aivan in Part I.	23b. Dtd tobac	cco usa contribu	ite to the cause of death?
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	es the grand pe de de de de de de de de de de de de de	Ohabetes Mel	litus, obesi	ty, brone	hitis,			
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tal		25. Was casa refarred to madical			26 Place of Death	(Check only ona)	2010	10140 245110
of Vital	Attending Physician: The law or death. ector: After this certificate has by the funeral director, page 2 fification: To Be Compi	axeminar?	Hospital: 1 Inpatiant 2	ER/Outpetient 3□ DOA	Wher	me 5 Residence	e ClOther /Sr	agaifu)
of	Phys rethis anal di	27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of lnjury W		28d. Dascribe how i		Jecny)
Division	ding th. Afte fund	1 Natural 5 Panding 2 Accidant invastigation			ork? ☐ Yes 2 ☐ No			
isi	dea ctor.	3 Suicide 6 Could not be		oma, farm, street, factory, officity)	a	28f. Location (Stree	and Number or	Rural Routa Number,
Š	tal or Attending Pris after death. al Director: After to led in by the funeral Certification:	4 Homicida	building, etc. (Special	(y)		City or Town, S	itata)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 7	29a. Cartifiar 1 Cartifying Ph	ysician: To the best of my kno	owledge, death occurred at the ation and/or investigation, in my	time, date and place,	and dua to the cause	e(s) and mannar	as stated.
	thin 24 hour thin 24 hour the Funer impletely fill	one)	and manner stated.					
	To To To	29b. Signature and titla of cartifier	RESIDENT	// 29c. Lica	P 13 13	_	Data signad (Mo	
	1	Di by cour	INTERNA	L MEDICING	1 12 13	A	UGUST	28 1999
	X	30. Name and address of person who		m 00a) (Time Brint)	0.1	1		240
		BALGSVERAMAN	JAYAU	AKSHMI, 3	001,501	TANDVER	ST. 131	ALTIMORE, MD
	State	31. Data filad (Month, Day, Year)	32. Registrar's Signi					
	Registrar	SEP 0 1	1999 Piner	D. Spo	uls			
				/ / //				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death AV6UST CHARLES ROBINSON 5-40 AM 1499 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL NORTHWEST RANDALLSTUNN BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 1 → M 2 □ F If Under 1 Year 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) Days Months Hours 217-20 6052 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Nos 2 No Baltiner Tary/mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U517 WESTCHESTER RUAD 12. Was Decedent Ever in U.S. Armed Forces? De Yes 2 | No 1950 | If Yes, Give Year or Detes: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried Married 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry gy/Secondary (0-12) College (1-4or 5+) ostal Clerke BE grade 17. Famer's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) CHARLES KUBINSON. SAMA W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informant's Name/Relationship (Type, Print) ROAD BALTIMOR 91Ma FUBINO WESTCHESTER 20b. Place of Disposition (Name of cametery, cremetory or other p 20a. Method of Disposition 20c. Location - City or Town, State → Burlel 2 □ Cremation 3 □ Removel from State Owings Mills, Med FOREst 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Montane 22. Name and Address of Facility CHATMAN - HARRIS 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate tnterval Between Onset and Death CARDIOVASCULAR DISEADE Immediate Cause (Final disease or condition resulting in death) ATHEROGCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequenca of) Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 1. Natural 2 Accident 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician/Medical Examiner The law requires that the death certificate be executed Box 68760. P.0. Records, þ Completed of Vital Be edicai Certification: To After Division

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

ma 23a or 28a-f show

Home 2

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Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hygiene. and If it hem 27 is marked other than "natural", or the ury or other traumatic event, pr. Medical Energians up or other traumatic event, pr. Medical Energia

permit. Pages Department of Important: If It any injury or of

Physician

/Medical

Examiner

21215-0020

Baltimore, Maryland

Directo

Funeral

by

Completed

or Attending Physician: s after death. To the Hospital within 24 hours a To the Funerel C

State Registrar DHMH 16 Rev 6/95

Mb

29c. License number

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AUGUST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ROTNIES 5401 OLD COURT ROAD 5401 OUD

RANDIUS TOWN, MARY LAND

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

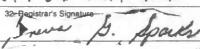
3 Suicide

29e. Certifier (Check only one)

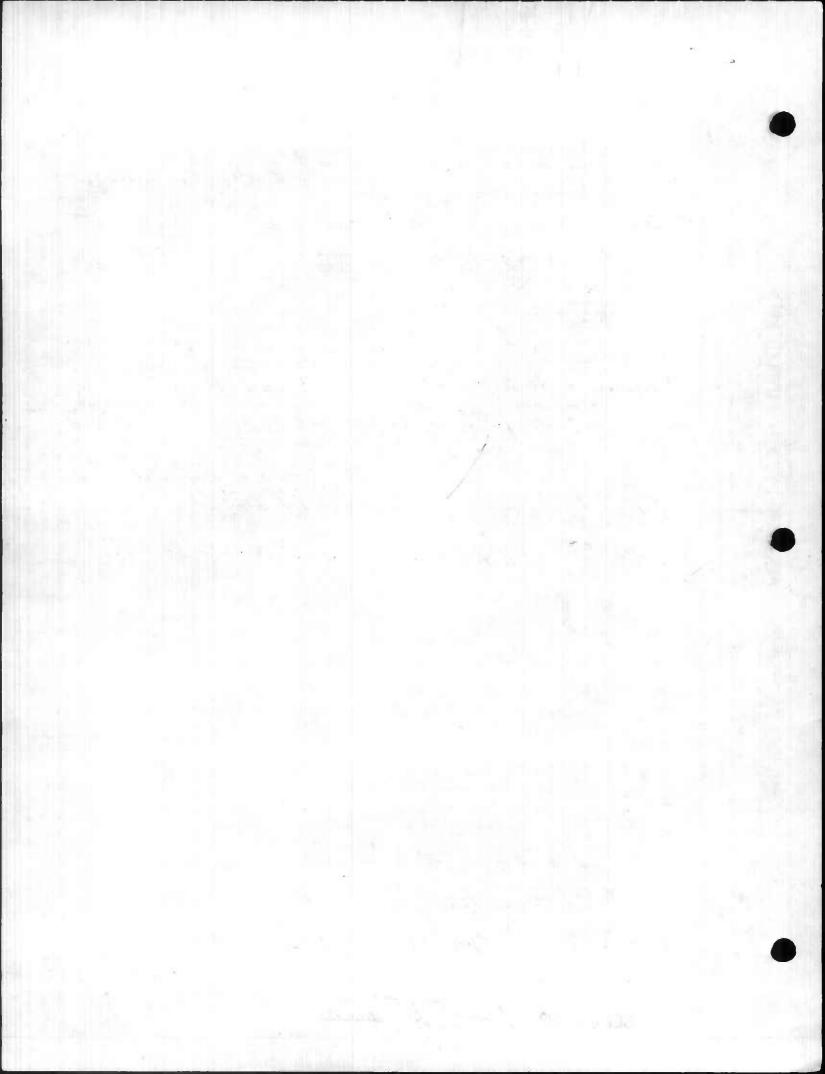
4 Homicide

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6 Could not be



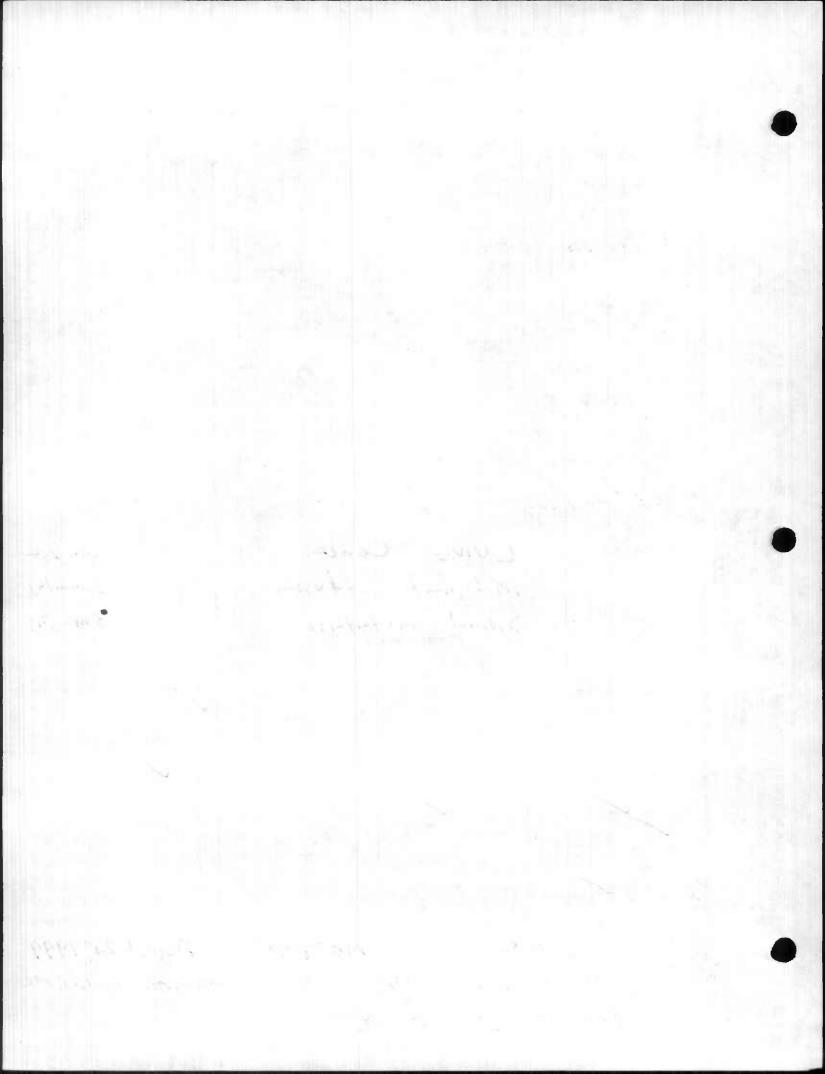
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 99 971, 15

						Ce	ertificate of	Death		Reg. No.	2 14	10
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	Exami		4a Facility/Neme (If not institution					4b. City, Town, or		h 4c. County o	of Deeth	
			250 S. PRESIDEN					BALTIMOR		N/A		
	Funeral Director		5. Social Security Number 138–40–5810	6. Sex 7. 4	Age (In yrs. 48	last birthday Yrs.	Montha Days			th .1'951	9. Birthplace (State Country) NEW JERS	e or Foreign SEY
	pu &		Usual Residence of Decedent 10e. Stete 10b. County		10c Cit	y, Town or L	ocetion				40d Incide	Clty Limits
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	Ne N	Director			DA.	LTIMOF				40- 09		
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	de F	Funeral	11. Maritel Stetus	12. Was Deceder Armed Force	nt Ever in U, is?	S. 13.	Was Decedent of	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race Bleck	- American Indien,	
21215-0020	ar, or h	by	1 Never Married 2 Men 3 Widowed 4 Divorced	ried 1 Tes 21 If Yes, Give	1 Tyes 2000		1□ Yes 2€No		Specify:			
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Baltimore	Page nent of ant: If it ary or		1 Buriel 2 Cremstion	3 XIRemoval from State		• LEBA	ematory or other pla NON	108)	8/29/99	ISELIN,	NJ.	
alt	Party Party		21. Signature of Funeral Service	Conget		2	22. Name and Addr	ess of Fecility	I I ENZINC	ONT C DDO	C TNO	
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		0	236. Part1. Enter the disease, or shock, or heart tailure. List	complications that caus	sed the deat	n. Do not er	nter the mode of dy	ing, auch es cardia	c or respiretory e	rrest.	Approxim	nate
	Physician		snock, or neart taxure. List	only one pause on each	n mne.						Intervat E Onset an	d Deeth
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	Examiner		resulting in death)	a		r as a conse		•				7
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0	ian a	m ×	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sai	nel	m	etaita	11			3 m.	m/4c
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Division of Vital	Attending Physician: The law requir v death: ector: After this certificate has been s by the luneral director, page 2 should	ü	27. Menna of Death 1 ONatural 5 Pendin	28a. Date of In (Month, L	Day Year)	28b. Time	of 28c. Inju	ork?	28d. Describe	how injury occurre	bed	
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Ĕ	or Attending I after death. Director: After I in by the luner	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 28e. Place of I building,	Injury - At ho etc. (Specify	me, ferm, s	treet, factory, office			Street and Numbe wn, State)	er or Rural Route N	um <i>ber</i> ,
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	Vithin Comp	M	29b. Signeture and title of contiling	7			29c, Licen	se number			(Month, Day, Year	-
			10/16	u			MA	T891		Ann	1281	999
	12		30. Name and suppose, of person	who are pleted cause of	f death (Item	23a) (Type	Print)	,,,,		1,0,0		
	10		31. Dete tiled (Month, Day, Year)	13 wesc	strar's Signa	N	00	nin	mem	my	128,1	ITAL
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28,1999° August 11:57 p.m. EDNA MARIE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MARYLAND GENERAL HOSPITAL 8. Date of Birth (Month, Dey, Year) Dec. 13, 1937 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2K)F Days Hours Months OHIO 61 Yrs. 213-34-4592 Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? U.S.A. 1312 S. HIGHLAND AVENUE 21224 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ○ (No If Yes, Give Yeer or Detes: 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) FRANCIS E. MASON FRANCES M. WHITE 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET BROWN/ NIECE 1691 WEIRICH AVENUE, WASHINGTON, PA. 15301 20a. Method of Disposition XIX Burial 2 □ Cremetion 3 □ Removal from State 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD CEMETERY BALTIMORE, MD. 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximeta Intervel Between Onset end Deeth PULMONARY EDEMA Due to (or es e consequence of): Immediata Cause (Finel disease or condition resulting in death) END STAGE RENAL DISEASE Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last SEPSIS SHOCK AND Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes an eutopsy

Physician /Medical Examiner

permit. Pages 1 and 2 should be Department of Health and Merial Important: If Itam 27 is marked of any injury or other traumatic eve

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

Name 23a

natural, or

filed within 72 hours after death

Saltimore, Maryland 21215-0020

P.O. Box 68760.

Records.

Division of Vital or Attending Physician: Director

Funeral

Completed

Be

2

Physician/Medicai þ

attending physician and for use as the burial-transit sate has been signed by page 2 should be detac Be Completed certificate Certification: To this funeral After within 24 hours after death.

To the Funeral Director: Al completely filled in by the fu

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □ Yas 2 No 1 ☐ Yas 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier hendeh 29c. License number 89346 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

MARYLAND GENERAL HOSPITAL CHANDOK ARUN 0/0 MD

State Registrar

completely filled in by

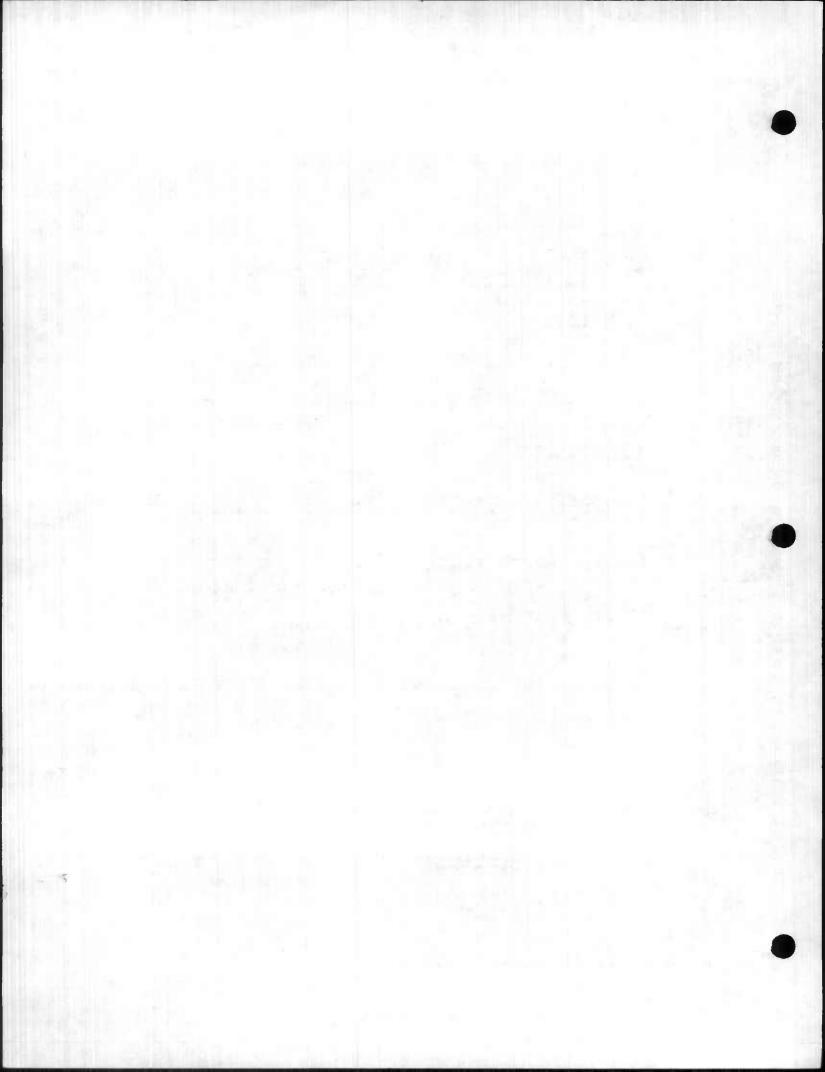
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Hospital

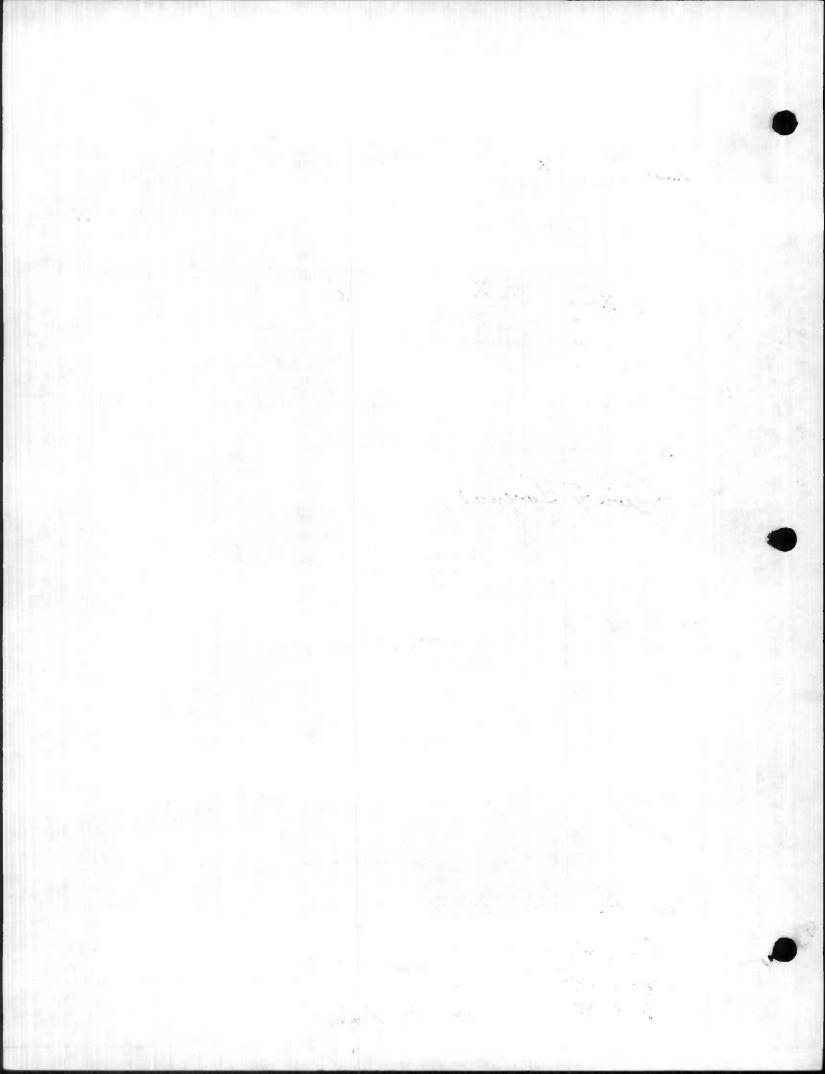
To the

31. Date filed (Month, Day, Year) SEP 0 1 1999

32. Registrer's Signature



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25. Was case referred to medicel axaminer? 1	entificet ling phy sees th	Pale	resulting in death) l	ast			000101	JI 63 6 CO136	quence o	.,.								
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Registrar SEP 0 1 1999 Inwa G. South					200	32 Regis	trer's Sign	eture										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 13:15 11/19m 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Montgomery = 20034 derick perman sidence own If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) S. Birthplace (State or Foreign Country) Min 187 M 2□ F Months Deys Hours 254-58-1124 62 23, Tennessee Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20034 Frederick Road #24 20876 USA 14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) 5+ Physician Medical 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) John W. Rosser Lucille Gaugh 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Diane P. R. Love/Wife 16508 Alden Avenue, Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Donation 5 Other (Specify) Anatomic Gift Foundation 8/23/99 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a Part Enter Mr. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximata interval Between Onset and Death Immediate Cause/(Final disease or condition resulting In death) Dua to (or as a consaquanca of). Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was casa rafarred to medical examinar? 1 □ Yas 2 □ No 26. Place of Death (Check only ona)

Physician /Medical Examiner

injury or

Physician

/Medical

Examiner

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Funeral

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Completed

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Funeral

Director

item 27 is marked other than "natural", or itema 23a or 28a-1 show other trsumatic svent, the Medical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter death Department of Health end Mentel Hygiene.

Baltimore, Maryland 21215-0020

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Physician/Medical

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Completed

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Certification: To

Medical

ician and buriel-trans physician signed by t hes funeral director,

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific.

Division of Vital Records, P.O. Box 68760

27. Manner of Daath

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2 Accidant

3 Sulcide 4 Homleide 29a. Certifian

atricia

Hospital: 5 Pending

investigation 6 Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Tima of

Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Phyeician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number

1 Yas

29d. Dete signed (Month, Day, Year)

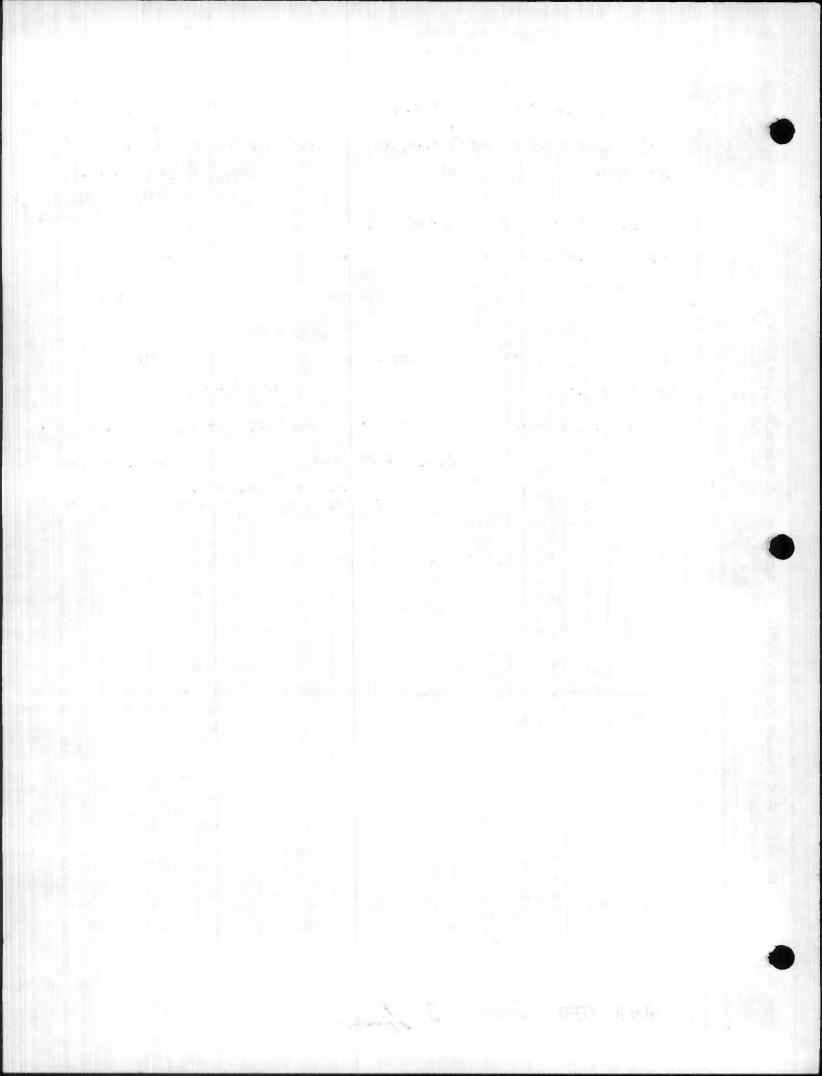
30. Name and address of person who co

31. Date filed (Month Pov Year) SEP 0 1 1999

32. Registrar's Signature

State Registrar

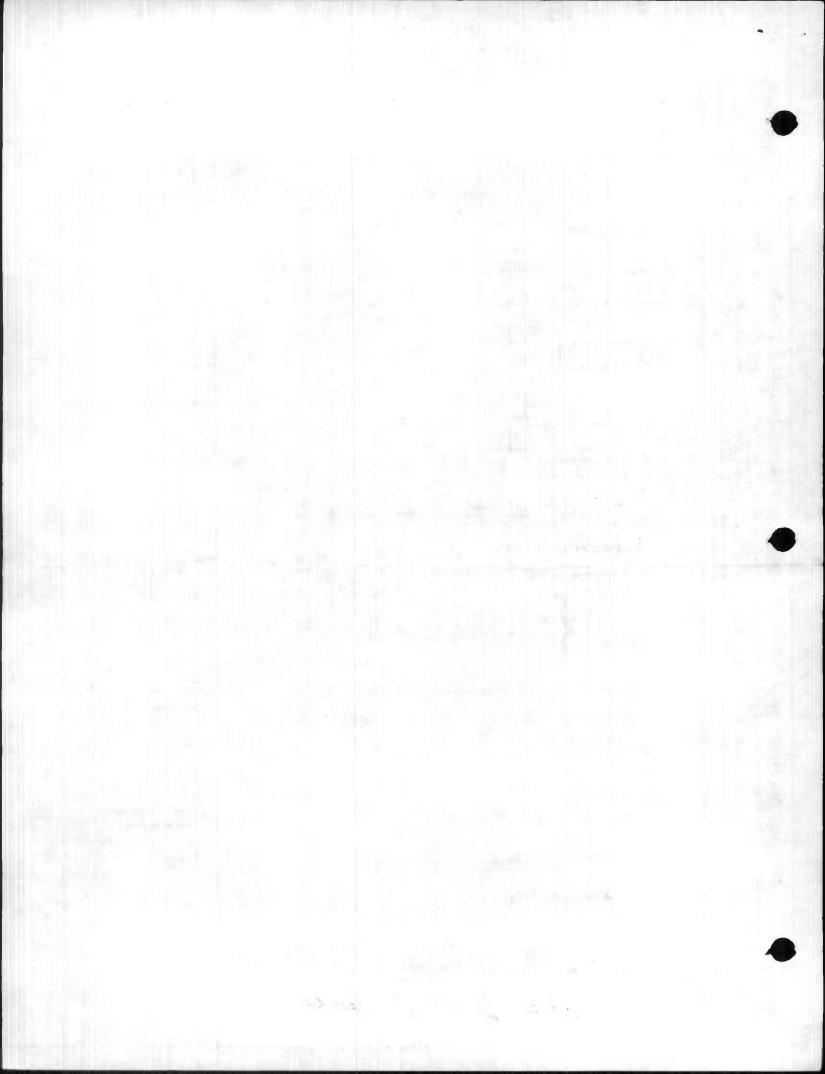
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State of Maryland	/ Department of H	lealth and Mental Hygie
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** RAY AUGUST 29 1999 12:40 am MOZELLA /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSP TAL BALTIMORE NA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 10 M 20 F 218.36.1423 MD Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Director NIA MO 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? KOAD WOODINGTON Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates; 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2☑No Specify: p 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within in Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "n any injury or other treumatic avent. In Electron." College (1-4or 5+) Elementary/Secondary (0-12) EMERGE UMAN DERVICE COORDINATOR GED 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) 8 ERNEST THACKER MOZELLA KOBINSON 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTO KAY LEWIS EVERALL MD. 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) Date 20c, Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State WESTERN CEMETERY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 09.02.99 22. Name and Address of Facility 21. Signature of Funeral Service Licenses VAUGHN C. GRÉBUE FUNERAL SERVICE 5151 BAUTO, NATE PIKE, 21229 BAUD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart faiture. List only one cause on each lina. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final UREMIA disease or condition resulting in death) 2 days Examiner Due to (or as a consequence of): Examiner MULTIORGAN SYSTEM FAILURE 4 days the burial-transit certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760. attending physician LOULT RESPIRATORY DISTRESS SYNDROME 7 days Physician/Medical Due to (or as a consequence of) 55 188 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yea 2⊠No 3 Probably 4 Unknown LUNGTRANSPLANTATION IDIOPATHIC PULMONARY Division of Vital Records, by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed Deed FIBROSIS completion of cause of death? page 2 has Pho Pho 1⊠ Yes 2□ No 1 ☐ Yes 2 No certificata 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2⊠ No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After it 1 M Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide edical 29a. Certifier 🅍 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and dua to tha cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Savid E. Koplan, mo RES -000 august 29, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANING. KAPLAN, MD; TOWER IND; GOO N. WOLFE ST., BALTIMORE, MD 21287 32. Registrar's Signature 31. Data filed (Month, Day, Year) doorthe State SEP 0 1 1999 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 30, Joseph C. Scott, Sr August 1999 1:00pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM FORT HOWARD 8. Date of Birth (Month, Day, Year) July 21, 1917 If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 20 F Months Yrs. 218-05-4503 July Rices, Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Name 23a or 28a-f show must be notified at N/A 1 ☐ Yes 2 ☐ No Baltimore Directo 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21224 155 Grundy Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give altimore, Maryland 21215-0020 'netural', or 1 Yes 2 No Specify: Specify: à Black 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Sherman Williams Paint Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Company 12th grade Janitor 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be next of Health and Mental int: If New 27 is marked o Mattie Marshall 2 James G. Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Malting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 21228 1206 Westerlee Place Apt 1C Catonsville, Md Department of Health Important: If Nem 27 Joseph C. Scott, Jr - Son 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Botal 2 ☐ Cremation 3 ☐ Remove if from State 20c. Location - City or Town, State ò 4 060 ation 5 Other (Specify) Crownsville Veteran Cem 9-3-99 Crownsville, Md 21. Sig of Funeral Service Lice 22. Name end Address of Fecility 21215 March F/H West DON come 4300 Wabash Avenue Balto, Md inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ir haart failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** 2 YEARS CANCER, LUNG /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequenca of): The law requires that the death certificate be exec Box 68760. physician Physician/Medical the Due to (or as a consequenca of) for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the signed by it HYPERTENSION 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown p been si 24b. Wara autopsy findings available prior to 24a. Was en eutopsy performed? Completed CHRONIC OBSTRUCTIVE LUNG DISEASE completion of ceuse of death? has DIABETIS MELLITUS 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 TYas 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending **Natural** ithin 24 hours after death, o the Funeral Director: After ompletely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) To the I 3 29b. Signeture and title of certifier 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SEP 0 1 1999

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AURORA

31. Date filed (Month, Day, Year)

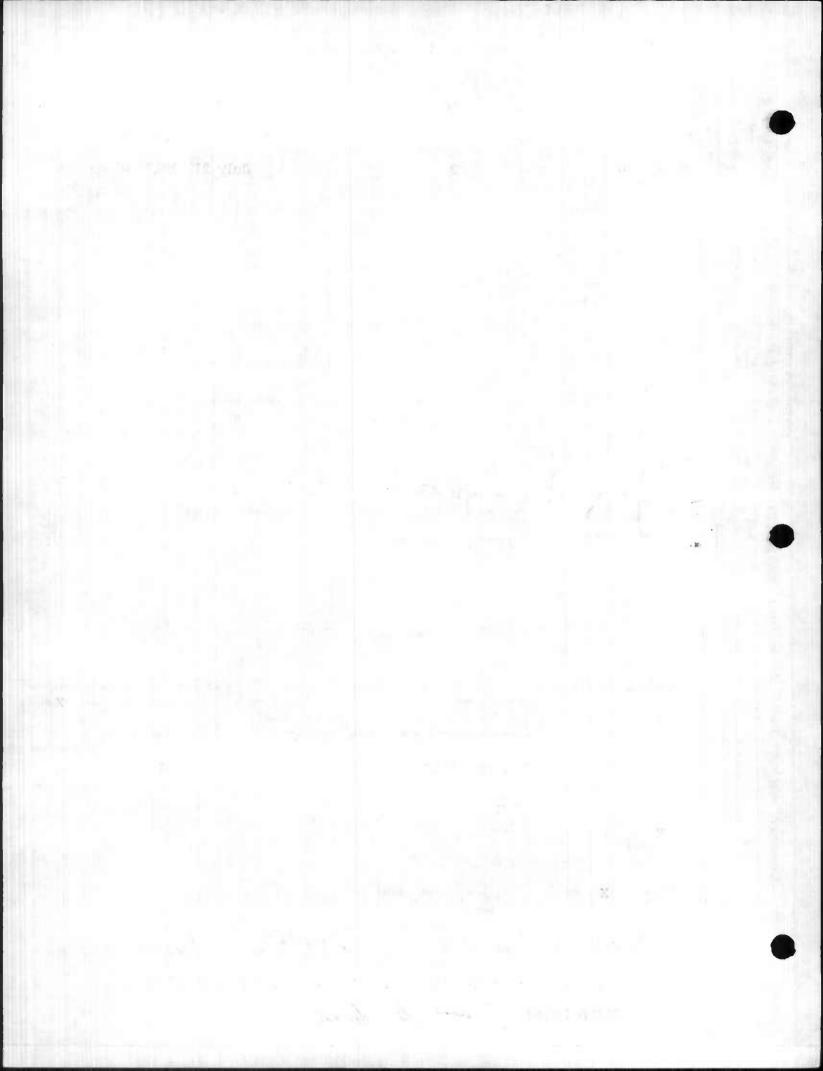
32. Registrar's Signature

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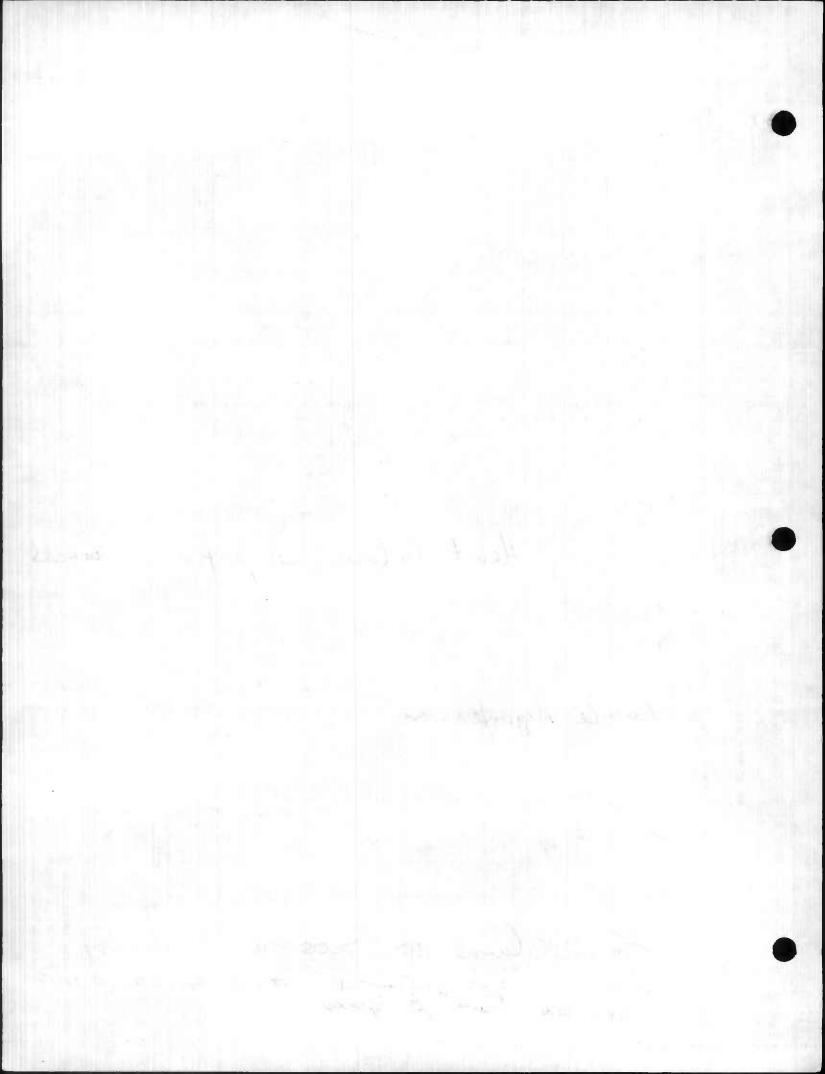
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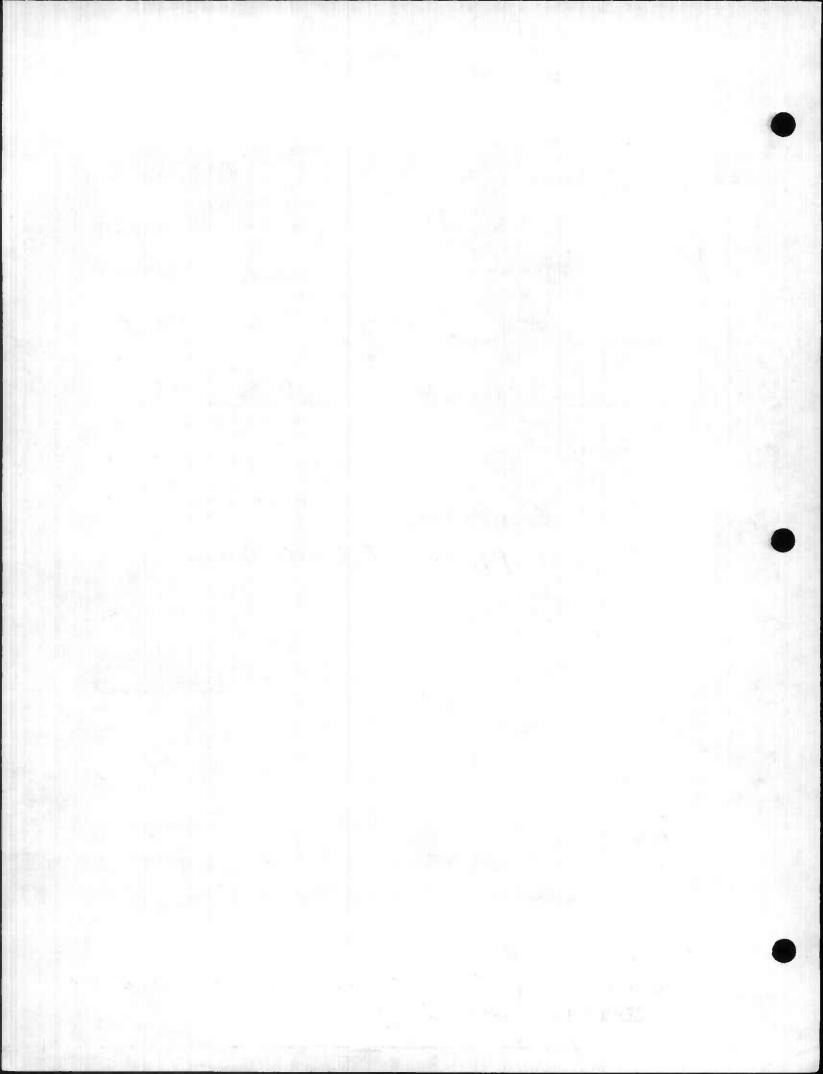


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61	ty Name (If not in S30 RESOL			m <i>ber)</i> 124			4b. City, Town, o		ocation of Death 4c. County of Death		
	Security Number			7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H		BALTI		olaca (State or Foreigntry)
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17. Fathe	r's Name (First, I	Middle, Last)			HOUSE	MILE	18. Mother's N	ame (First, Middle	OWN He e, Meiden Sumen		
MC	RRIS				SUMME	R	CLARA			(UN	KNOWN)
19a. Info	rmant's Neme/Re	elationship (7	ype, Print)		19b. Meilin	ng Address (Street	and Number or I	Rural Route Numi	ber, City or Town,	, Stete, Zij	Code)
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120	nod of Disposition Burial 2 Cren	nation 3 🗆		State	cemetery, cren	sition (Name of netory or other ple		Date	20c. Location		
	Donation 5 0			BE.		EMORIAL Name and Addre		8/24/99	RANDAL		
21. Signature of Furieral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21206											
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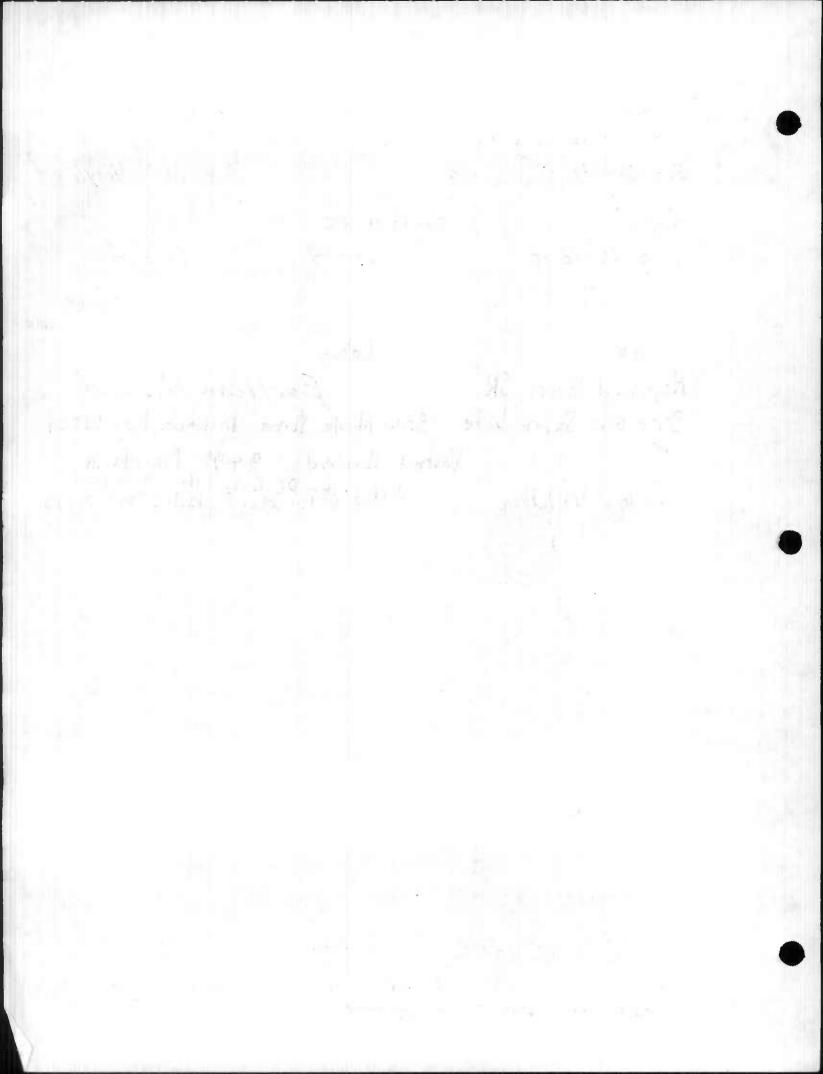
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Baltimore, Maryland 2121	yermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hypano. Important it files and Mental Hypano. Important it files and Mental Hypano. Important it files and Mental Hypano. Indicate the mental of the Medical Examiner must be notified at a pice. In the Medical Examiner must be notified at a pice.	To Be Completed by Funeral Director	10a. Stete Prince 10e. Street and Number 12509 Proxm 11. Mentel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grant processes of the company (0-12) 1246 17. Father's Neme (First, Middle, Last) Tessie 19e. Informent's Neme/Reletionship (7-10)	College (1-4or says Says Says Says Says Says Says Says	Ever In U, No 5+) 20b. Pc Hau the deeth	19b. Meilil 1314 lece of Dispo	Wash 101. Zip Wes Deced If Yes, spec I yes dent's Usue kind of wor Do NOT us Fing A ddress A H position (Nem metory or on EM. 2. Name en Warc ter the mode	lent of Hilly Cube I Occupy Rent of Hilly Cube I Occupy Rent done of the ratired Crew d Address d Address e of dyin	ispanic Origin, Mexican Specify: ation suring most 18. Mothe Mothe St. ye Motor soft Facility g, such es	of working	(First, Middle, M. C. Ster) Date 2 30-99	Blec Specify 16b. Kind of Bu Restura Taiden Sumam Scott City or Town, A. 1 Chester OI E. 1st,	That Cour A	ean indian, etc. ACK dustry	
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State of Maryland / Department of Health and Mental Hygiene Q

					(Certifica	te of L	Death		Reg. No.	1	76. 17
	Oharata		Decedant's Name (First, Middle, Las	it)					2. Date of De	ath		3. Time of Death
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0020	ours efter de rai", or item Examiner	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yas 2 ☐ No if Yes, Give Year or Dates:		if Yes, sp	ecify Cubar	spanic Origin? (: n, Maxican, Pue Specify:	Specify Yes or No rto Ricen, atc.)	Specif	ce - American ck, White, etc	ack
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			23a. Part I. Enter the disaase, or companies, or heart failure. List only of	lications that caused the	ne death. Do no	ot anter the mo	da of dying	, such as cerdia	ac or raspiratory a	rrast,	A	pproximate tervsi Between
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DIVISION OF VITAL	Attending Physician: or death. ector: After this certific by the funeral director,	ation: 1	27. Manner of Deeth 1 XNaturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		ne of	28c. injury Work		1	now injury occur	1.1.27	
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	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical (29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	aicisn: To the best of r iner: On the basis of ex and manner state	xeminetion and/	deeth occurre or Investigatio	d at the time n, in my opi	e, date and place inion, death occ	e, and due to the urred et the time,	cause(s) and me date and place,	enner as state and due to th	ed. e ceuse(s)
	To the To the comp	M	29b. Signature and title of certifier	1 20	1		c. License			29d. Date signe	d (Month, Da	y, Year)
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			30. Neme and eddress of person who g				d Me	dical	System	22 S.	Green	ne St
	Sta Registr		31. Date filed (Month, Dey, Year) SEP 0 1 1999	32. Registrar's	s Signature	Spark						

Registrar



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month STORTO 5:45 AM MARIE August 31 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Johns Hopkins 4c. County of Death Lakeside Nursing HOME Geriatria Center BALTIMORE Hours Min. 8. Dete of Birth (Month, Day, Year) March 27,1915 If Undar 1 Yaer 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 5. Social Sacurity Number Months 1 M 2 F MARY LAND 217-09-1876 84 Usuel Residence of Decadent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No BALTIMORE DUNDALK 10e Street and Number 10f Zlo Coda 10g. Citizen of What Country? 103 CENTER PLACE 21222 U.S.A. 14. Race - American Indian, Bleck, White, atc. 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11. Maritai Status 1 ☐ Nevar Married 2 ☐ Married ☐ Yas 2 No I Yas, Giva 1 ☐ Yas 2XXNo Specify: Specify: 3 Widowed 4 Divorced Year or Datas: WHITE 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) SEAMSTRESS LONDON FOG 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) FELIX STACHOROWSKI JOSEPHINE JARZYNSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) NICHOLAS STORTO/SON 409 ELRINO STREET, BALTIMORE, MD. 21224 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c Location - City or Town, Stata 20a. Mathod of Disposition Data WBurial 2 ☐ Crametion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) 9/3/99 STANISLAUS CEM. BALTIMORE, MD. 21. Signetura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility LILLY & ZEILÉR INC. FUNERAL HOME 23a. Part1. Entar tha disaase, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, Approximately a such as cardiac or raspiratory arrast, Approximately a such as cardiac or raspiratory arrast, 21231 Approximate Intarval Between Onsat and Death Chronic Heart Failure Immediate Causa (Final diseesa or condition rasulting in death) Due to (or as a consequence of): heave disease covonary Sequantielly list conditions, if eny, leading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that Initiated avants rasulting in death) Lest Dua to (or as a consaquenca of): Dua to (or as a consequanca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No Diabetu Mellitus 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yas 2 No 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residenca 8 Othar (Specify) 1 Yas 2 No

28c. Injury at Work?

🖄 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. Licanse number

10054067

1 ☐ Yas 2 ☐ No

28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

August 31

29d. Data signad (Month, Day, Year)

1999

/Medical Examiner and **burial-trar** certificete be execu physician the 62 980

Physician

Physician

/Medical

Examiner

Funeral

Director

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Hygiene.

Peges 1 and 2 should be tent of Health end Mental int; if item 27 is marked or

t of Health e

ö Department of Important: If any Injury or price. Director

Funeral

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Completed

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with the Maryland

death

filed within 72 hours after

altimore, Maryland 21215-0020

Examiner signed I hes certificate this funeral After

Physician/Medical p Completed Be 20

Certification:

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Records, P.O. Division of Vital or Attendination after death.

> State Registrar

29b. Signatura and titla of cartifian

Sen

27. Mannar of Death

1 Natural

2 Accidant

4 Homicida

(Check only one)

3 ☐ Suicide

29a. Certifiar

5 Panding

Invastigation 6 Could not be datarmined

Hopkins Bayriew Prive 32. Registrar's Sonatura

28a. Data of Injury (Month, Day Yaar)

Baltimore MD 21224

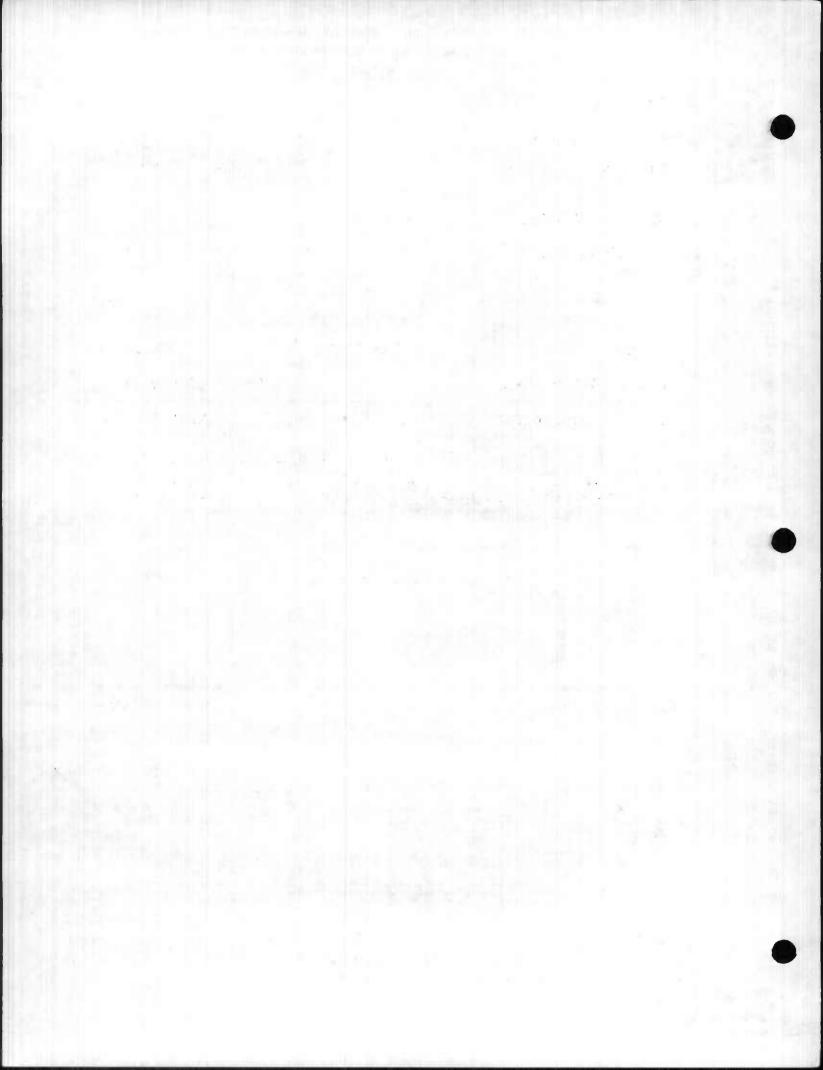
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) SEVIL YASAR IND Johns 143 pl. ins

28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

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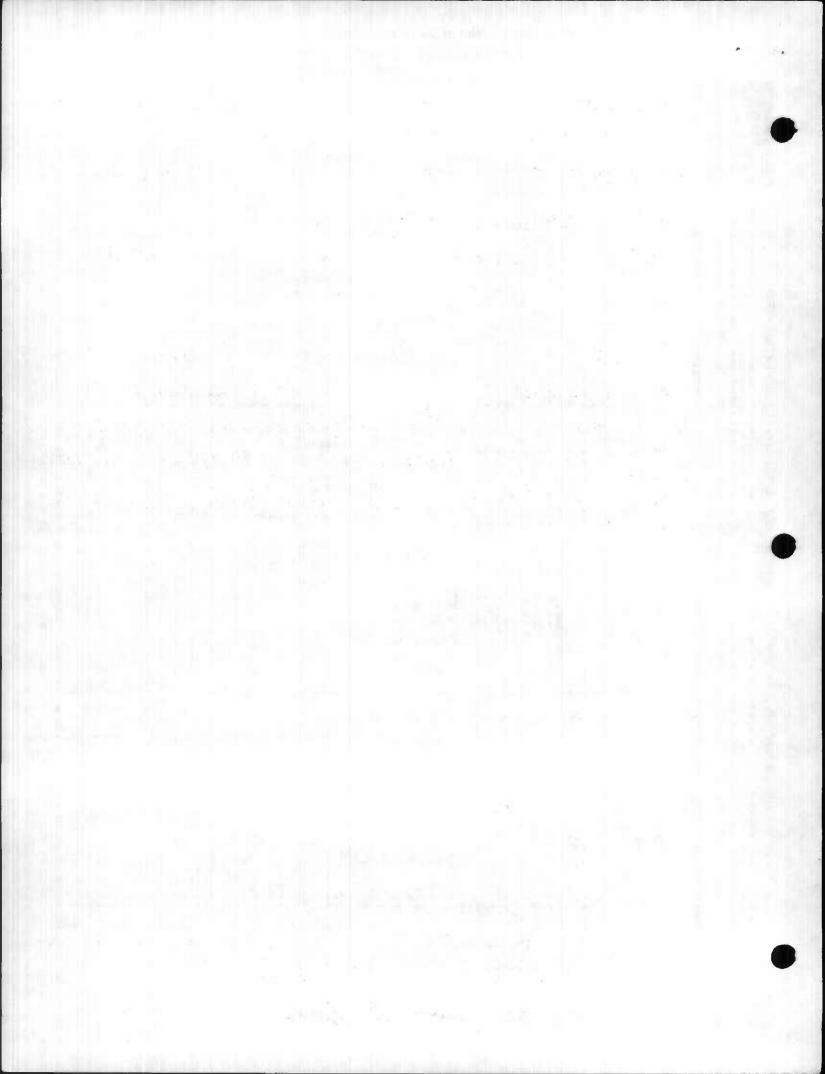


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	Examir		4a Facility Nama (If not institution, giva si		1 0		c. County of Death	
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	Funeral Director		5. Social Sacurity Number 6. Sax 219-07-4939 Usual Rasidance of Dacedent	M 2□ F 7. Aga (In yrs. last b	rthday) If Under 1 Yaar If Under 24 Months Days Hours If	Ain. (Month, Day, Yea		place (Stata or Foraign stry) and
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	eme	Funeral	11. Marital Status	Was Decedant Evar in U,S. Armed Forcas?	13. Was Decedant of Hispanic Origin' If Yas, specify Cuban, Maxican, P	? (Spacify Yes or No- uarto Rican, atc.)	14. Race - Amaria Black, Whita,	
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Division of Vital Records, P.O.	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the bunel-transit	Completed				24a. Was an au performad'	a	vailabla prior to omplation of causa daath?
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0	ng Pt ther th		27. Mannar of Death 1 Naturel 5 ☐ Panding	28a. Date of Injury (Month, Day Year) 28b.	Tima of 28c. Injury et Injury Work?	28d. Dascribe how in	jury occurred	
Sio	eeth. or: A	cati	2 Accident invastigetion 3 Sulcida 6 Could not be		M 1 ☐ Yas 2 ☐ No			18
N	or Att	Certification:	4 Homicide dataminad	28a. Place of Injury - At homa, f building, atc. (Specify)	arm, streat, factory, office	28f. Location (Streat City or Town, St	and Number of Hui ete)	ai Houta Number,
	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2				e, daath occurred at tha tima, data and p			
	in 24 he Fu plete	edical	(Check only 2 Medical Examin-	er: On the basis of exemination a end mennar stated.	nd/or Invastigation, in my opinion, daath			
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	Sta		31. Data filed (Month, Day, Yaar)	32. Ragistrer's Signeture	/ /			

State Registrar

32. Ragistrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day Year **Physician** Marie N. Slattery August 29 /Medical 1999 12:20 PM 4a. Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Gilcrest Center Towson Baltimore If Under 24 Hrs. Hours Min. If Undar 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 3, 15 Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 X F Yrs. 212-22-6236 86 Director 1913 Usual Residence of Decedent 10a. State 10c. City, Town or Location ahow 10d. Insida City Limits be notified 1 ☐ Yes 2 No 28a-f # MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 j 1836 Marshall Rd 238 21222 USA Funeral items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: ŏ Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White 'natural', Completed Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry than Elamentary/Secondary (0-12) Hygiene. College (1-4or 5+) Homemaker Own Home Department of Health end Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Albert Baker 0 Catherine Bena 19e. Informant's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Vincent Slattery /son 1836 Marshall Rd Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, State cemetery, cremetory or other placa) t Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 1 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 1999 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23a. Part1. Enter the disease, or complications that ceused the deam shock, or heart failure. List only one ceuse on each line. Do not enter the mode of dying, such as cerdiac or respiratory arrest Approximate Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) A DMA ears Examiner Due to (or es e consequence of) Physician/Medical Examin certificate be executed ician end buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Causa (Disease or Injury Due to (or as a consequence of): that initieted events resulting in death) Last the Due to (or as a consequence of) 98 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No þ Completed 24e. Wes en eutopsy 24b. Were autopsy findings available prior to performed? completion of ceuse of death? page 2 s 1 ☐ Yes 2 KNo 1 ☐ Yes 2 ☐ No director Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) axeminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) pice 2 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred • Hospital or Attending Pi n 24 hours efter death. • Funeral Director: After the bletely filled in by the funera Certification: 5 Pending investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

of Division To the Hospital o within 24 hours eff To the Funeral Di completely filled in

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State Registrar

edical

29a. Certifier

30. Name

29b. Signeture and title of or

31. Dete filed (Month, Day, Year) SEP 0 1 0 1 1999

and address of person who completed cause of deeth (Item 23e) (Type, Print)

A. R. Tey GBMC 6701 A

no

M. Chimles St. Bolto. md 21204

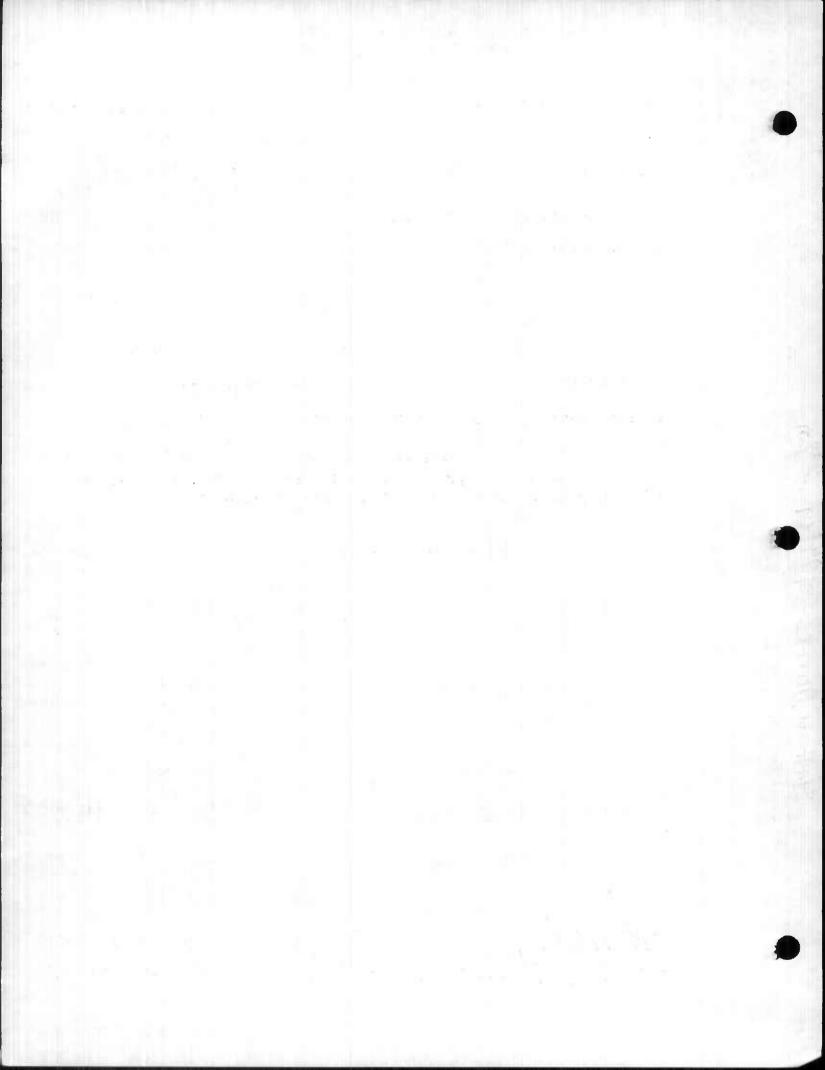
Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. License number

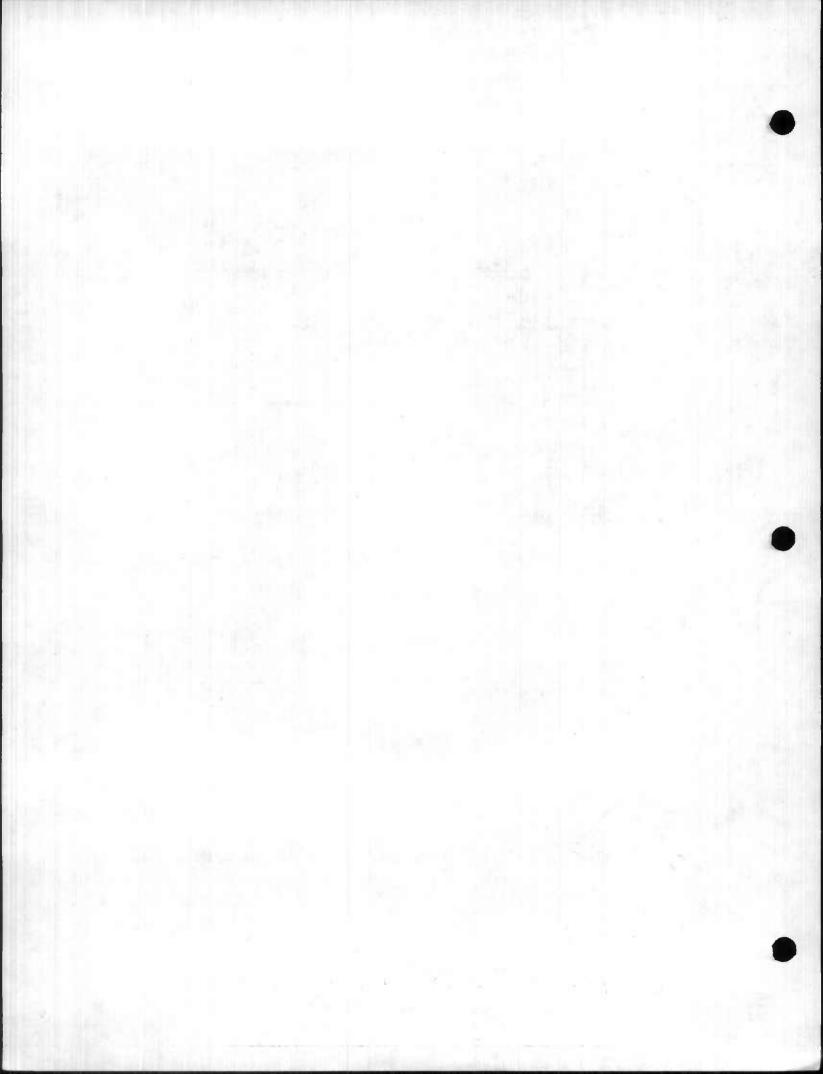
29d. Date signed (Month, Dey, Year) August 30, 1999

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

	Certific	ate of Death		Reg. No.	J 600	1 4 6 1
Physician	Decedant's Name (First, Middla, Last)		2. Date of De Month	eth Day	Year	3. Time of Death
/Medical	George E. Smolko		AUGUS		999	1300 PM
Examiner	4a Facility Nama (If not institution, giva street and number) 7214 BIRCH AVENUE	4b. City, Town, or I	ocation of Death		of Death IMORE	
		nder 1 Yaar If Undar 24 Hrs.	8 Date of Bird			aca (Stata or Foreign
Funeral Director	218-26-6756 1 Moni 2□F 70 Yrs. Moni Usual Rasidance of Decedant	ths Days Hours Min.	8. Data of Bird (Month, Da Jan 26		Count MD	iny)
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23a or 28a-f show unt be notified at el Director	10e. Street and Number 7212 Birch Ave	Zip Code 21222		10g. Citizen of V USA	What Count	try?
or Herra 23a miner must. Furneral	11. Marifal Stetus 12. Was Decedent Ever in U,S. 13. Was Decedent Ever in U,S.	ecedant of Hispanic Origin? (S specify Cuban, Mexicen, Puert	pecify Yes or No	- 14. Rac	e - America	
Examine by Fu	1 Never Marriad 22 Marriad 1 Vac 2 No.	s 2 No Specify:	o Rican, etc.)	Specify	ack, Whita, atc. ^{ify:} White	
atal a	15. Decedent's Education (Specify only highest grade complated) (Giva kind of	Jsuel Occupation	kina	16b. Kind of Bu	usiness/Ind	ustry
t, the Medical Completed	Elamantary/Secondary (0-12) College (1-4or 5+)	work done during most of wor T use retired)				
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c ever	17. Father's Name (<i>First, Middle, Last)</i> John Smolko	18. Mothar's Nen	rine J		18)	
T F		ress (Street and Number or Ru			State Zin	Codel
r trans		Birch Ave		more,		
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qury or	4 Donation 5 Other (Specify) Metro Crei	matory	1999	Catons		
any ir		a and Address of Eacility nnelly Funer 10 Sollers P				lk
as the buriel-transit as the buriel-transit ledical Examiner	Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence b. Sequentially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Disaas or Injury thet initiated events Due to (or as a consequence consequence consequence)	of):	Kr V	Rose		
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etached letached Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng ceusa given in Part I.		tobacco uss co Yes 2□ No	ntributs to	the cause of death?
2 should			24a. Was perfo	an autopsy ormed?	con	ra autopsy findings allabla prior to appletion of ceuse death?
page 2			100	Yas 2 No	D	Yes 2□ No
, o o	25. Was casa referred to medicel	26. Placa of Dee	th (Check only	ona)		
5 O O	examinar? Yas 2 No Hospital: 1 Inpatiant 2 ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 Resi	dence 6 50th	ar (Specify	SCENE
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Directo Directo d in by t	3 ☐ Suicide 4 ☐ Homicida 8 ☐ Could not be detarmined 28a. Place of fnjury - At home, farm, street, farm building, etc. (Specify)	ctory, office	281. Location (. City or To	Street and Numb vn, Stata)	per or Rure	l Route Number,
Within 24 hours after To the Funeral Dire completely filled in b Medical Certi	1 Certifying Physician: To tha best of my knowledga, death occur 2 Medical Examiner: On tha besis of axamination and/or invastiga and mannar stated.					
To the	29b. Signature and title of cartifler	29c. License number		29d. Date signe		
	· Cartolews	O.C.M.E.		AUGUST	31,	1999
(et, Baltimore,	, Maryla	nd 2120	1	
State Registrar	31. Dete filed (Month, Day, Year) SEP 0 1 1999 32. Registrar's Signatura	sports				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND #9 & 12-14 PER A.B. G775 9-1-99 J.A 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SENKBEIL Month LISELOTTE 03:50 AM 30 07 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) SALISBURY If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) ARCA DIA WICOMICO MEDICAL ASSOCIATES 5. Social Sacurity Number Birthplace (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 10 M 208F Months 736066 Yrs. GERMANY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico 1 Yas 2 No 10e. Street and Number 10g. Citizen of What Country? USA 805 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 14. Raca - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: WHITE 3 Widowad 4 □ Divorced 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT usa retired) College (1-4or 5+) Elementary/Secondary (0-12) tome maker OWN HOME 18. Mother's Name (First, Middla, Malden Sumeme) 17. Father's Name (First, Middle, Last) ERNST OTTO FRITZ NEUPAUER AUGUSTA MINNA 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) GOOD MEDITERREAD D. OCERN CITY, MID 21842 Data of Disposition (Name of Data 200. Location City or Town, State Christine SENKBEIL, DAUGHTEN 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensae 22. Name and Address of Facility NOTHY Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, in its control of the caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, in its control of the caused on a cause on a cause on a cause on a cause on a cause of the caused the death. Approximate Interval Batween Onsat and Death PANCREAS Immediata Causa (Final 3MONTHS disaase or condition resulting in death) Dua to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NONE. 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 Yes 2 No

Physician /Medical **Examiner**

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signed by the e

director.

funeral

Box 68760. certificete be

Division of Vital Records, P.O.

I or Attending Physician: after death. Director: After this certifica

Hospital 24 hours a To the Hospital within 24 hours To the Funeral I Examiner

Physician/Medical

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Certification:

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Physician

· /Medical

Examiner

10a. Stata

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Director

Funeral

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Completed

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Director

7 is marked other than "natural", or itema 23s or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural". or hear

Baltimore, Maryland 21215-0020

the Marylend

with

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa refarred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. injury at Work? 28b. Time of 5 Pending Investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 0 1 1999

4 Homicide

1 Decritifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, and dua to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

050759

MO. chon

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) CHARLES

540 RIVERSIDE DR. SUITES

State Registrar FOLA SHADE 32. Registrar's Signature

the solutionized Street THE REAL PROPERTY OF EXCELL FOR THE REPORTER HOUSER HOUSER DEPENDENT Emiliar Stillett, Million of Jack St. Scott Co. Element y 40 July I THE THE STATE OF THE STATE OF THE PARTY OF THE STATE OF Maria and the second of the literal 16/2/2 April 652010 1 300 The 2 Louis

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** LIEUSI NORMAN E. SMITH · /Medical 4b. City, Town, or Location of Dulum 4a Facility Name (If not Institution, give street and number 4c. County of Death Examiner Bal sina TIMOVS N/A Imore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9-24-31 7. Age (In yrs last birthday) Birthplace (State or Foreign Country)
 MD . 5. Social Security Number **Funeral** Months Days Hours Min 67 Yrs 216-28-1302 Director Usual Residence of Decedent a so known as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 28a or 28a-f show other treumstic svent, the Modical Examiner must be notified at 1 Nes 2 No Director MD. N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3304 WINDSOR AVE. 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgln? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 ☐ Widowed 4 🎇 Divorced Completed 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) ould be filed was...d Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -10-CUSTODIAN JANITORIAL -0-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CHARLES HARRIS SARAH SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Haalth a Important: If item 27 is SARAH SMITH (MOTHER) 3304 WINDSOR AVE. BALTIMORE, MARYLAND 21216 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 9-1-99 western star cemetery BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VERNON R. BAILEY FUNERAL SERVICE 21. Signature of Funeral Service License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 mon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Examiner physician end the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or a) a consequence of); Box 68760. certificate be Physician/Medical that Initiated events resulting in death) Last Due to (or as a consequence of): as USB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? pege 2 s has 1 Tyes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) P L Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death funeral 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Pending investigation 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 24 hours 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and magnetistated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnetistated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical complataly (Check only one) within 2

State Registrar

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31. Date filed Month, Day, Year) 32. Registrar's Signature SEP 0 1 1999

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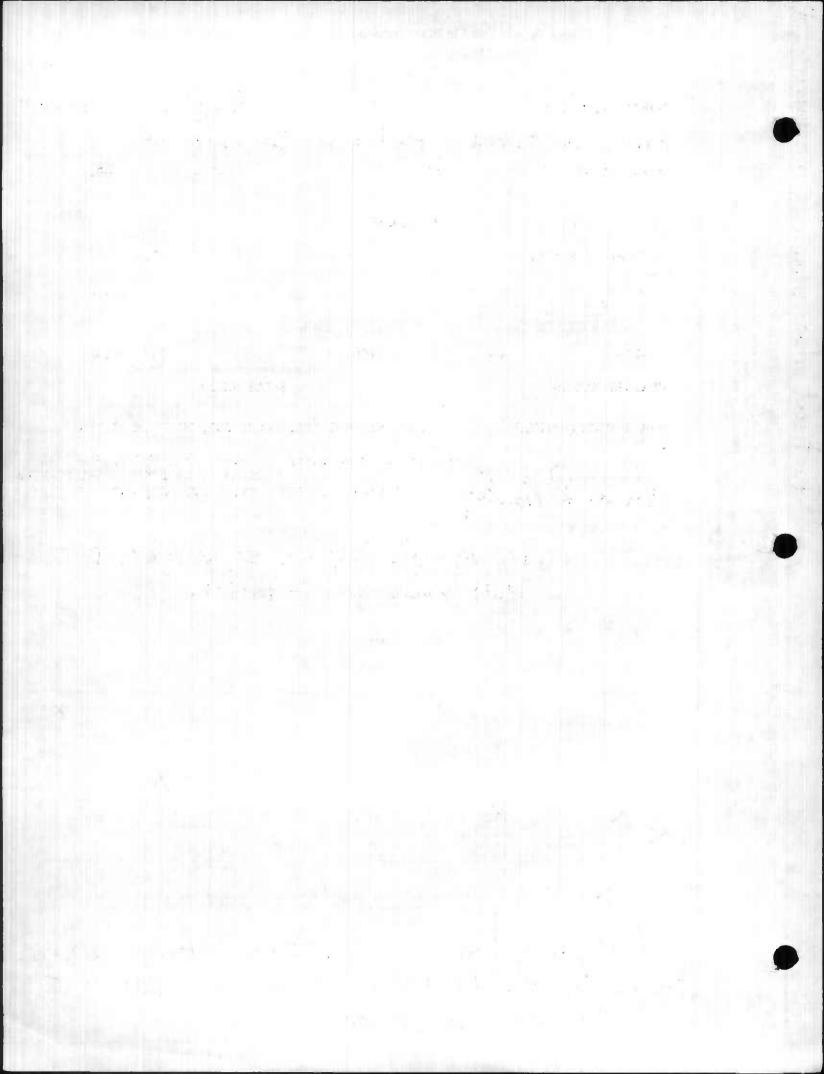
29b. Signature and title of certifier

30. Name and address of person who dample

cause of death (Item 23a) (Type, Print) W. Belvedo

29c. License number

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Madeline Stone braker 146 PM 27, August 4e Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical Examiner

Funeral Director

the Maryland 28a-f ahow traumetic avant, the Medical Examiner must be notified at b Items 23a death

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Heelb and Mental hygiens. Important: If Itam 27 is marked other than "natural", or Hanny Injury or other traumatic avants.

Physician 7Medical Examine

physician and the burial-transit The law requires that the death certificate be executed Box 68760. 980 P.O. signed by d Records, Division of Vitai or Attanding Physician: this After 1 24 hours after death.

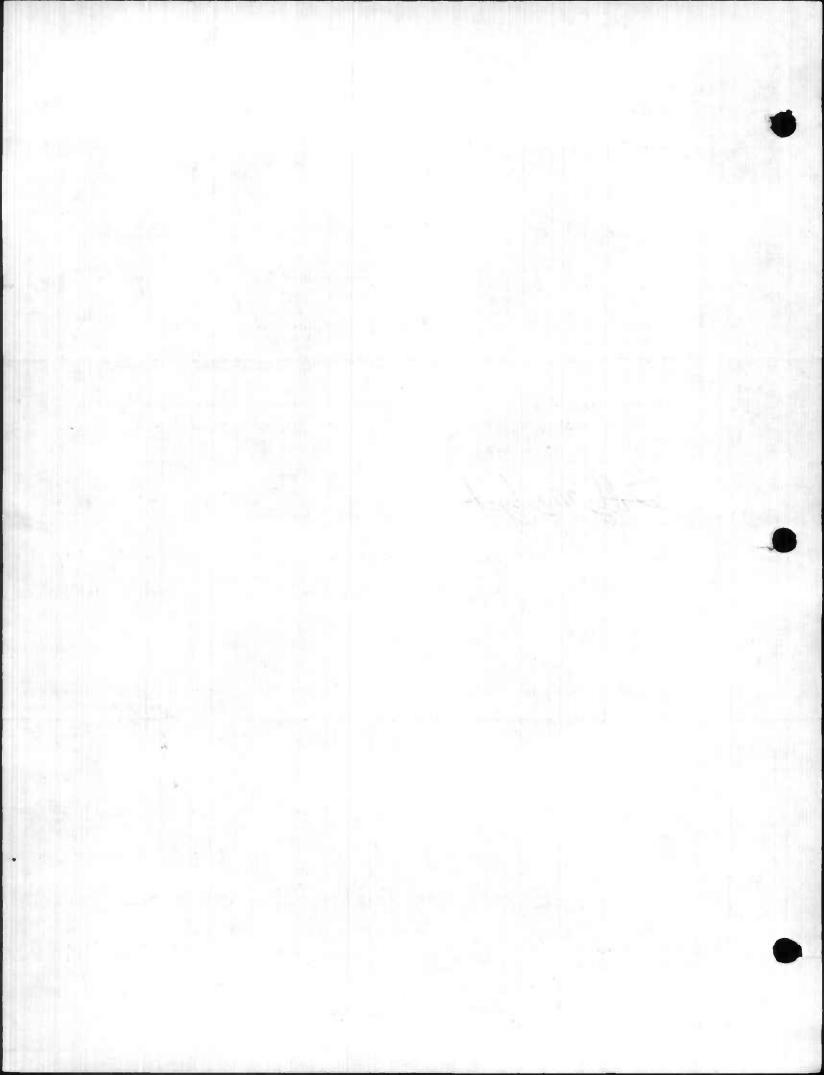
Johns Hookins
5. Social Security Number 6 Bayview Medical Center Boutimore B If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) IL Baltimore (7. Age (In yrs. last birthday) If Under 1 Yaar 6 Sax Birthplace (State or Foreign Country) 1□M 2XF Months Days 217-03-2427 83 Maryland Usual Rasidenca of Decedant 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21213 U.S.A. Funeral 3651 Lyndale Avenue 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Dates: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, atc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify. þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 10th. Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Unknown Margaret Madeline 19s. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Margaret Hansel / Daughter 3651 Baltimore MD 21213 Lyndale Avenue 20b. Piace of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Daurial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/1999 0aklawn Cemetery Baltimore 21. Signature of Funeral St 22. Nama and Address of Facility rvine Licensea John C. Miller, Inc. 6415 Belair Road Baltimore 21206 of hat caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and an enter the mode of dying, such as cardiac or respiratory arrest, and an enter the mode of dying, such as cardiac or respiratory arrest, and the mode of the 23a. Part1. Eri ar shock, or ha Approximeta Interval Between Onset and Death Immediate Cause (Final disease or condition rasulting in daath) congestive heart Examiner ocardial utarctro Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaase or injury Dua to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? myocardial infarction - history of 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 20 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatiant 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed causa of deeth (Item 23a) (Type, Print) Eastern Avenue, Bultimore, Maryland Shah 4940

State Registrar

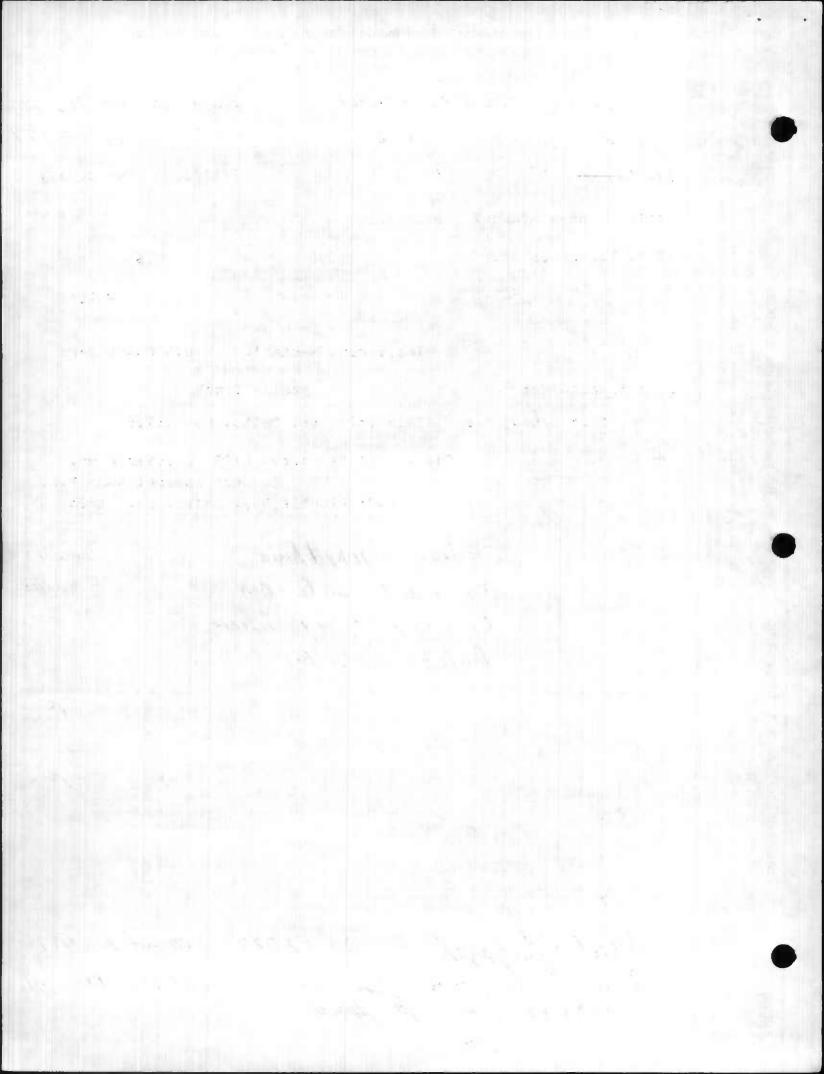
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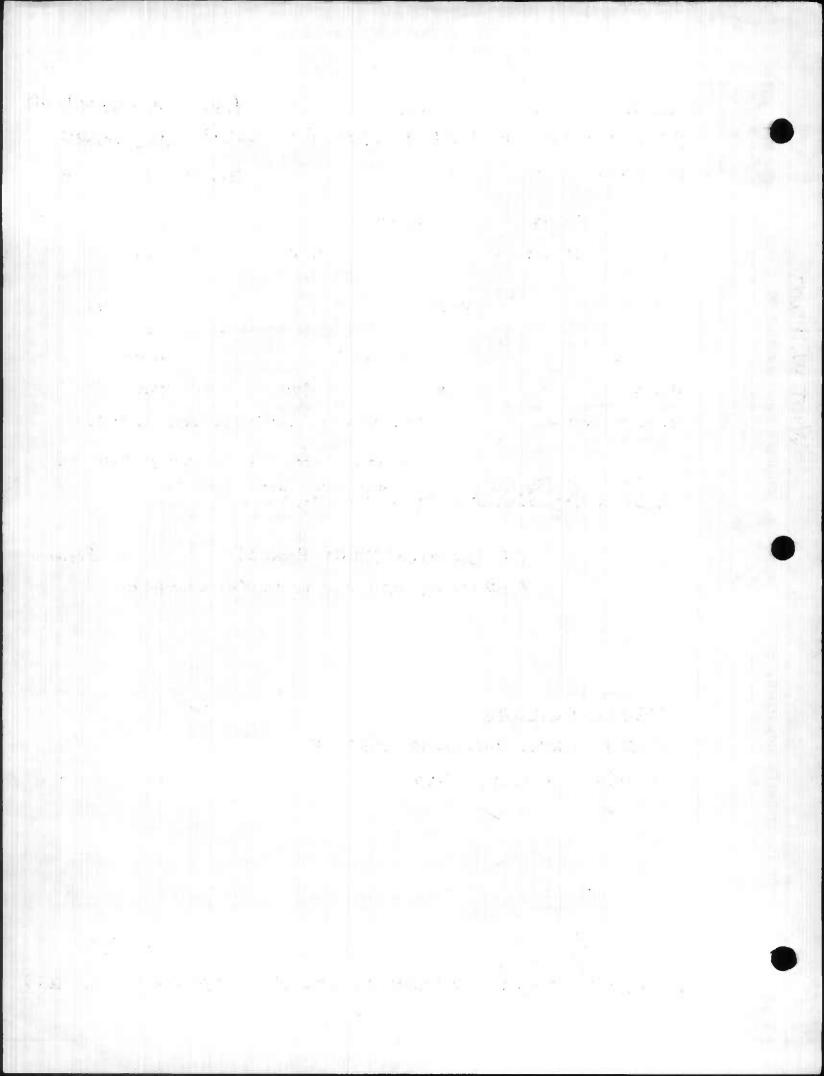


State of Maryland / Department of Health and Mental Hygiene

	D#5 PER F.H. G784 1. Decedent's Name (First, Middle, Last	st)		te of Death	2. Date of Deeth	g. No.	3. Tima of Death
Physician /Medical	WALTER	TOMA	SZENSK	./	August	36 1999	1027 PM
Examiner	4a Facility Name (If not institution, give		ENTER	4b. City, Town, or BALTI	ocation of Deeth	4c. County of Deeth	DEE CITY
Funeral Director	5. Social Security Number 6. S	ex 7. Age (In yrs	78 Yrs. If Under Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 1/19/2		place (State or Foreign Intry) Jersey
8 m	10a. Stele 10b. County	10c. C	ity, Town or Location				10d. Inalde City Limits
ms 23a or 28a-f show Livest be nothed at	Maryland Anne	Arundel H	Baltimore				1 ☐ Yes 2€No
n or 284 be not	10e. Street and Number			o Code	10	g. Citizen of What Cou	intry?
ural; or items 23a or 28a-fs al Examinet must be noutled ed by Funeral Director	11.2 N. Longeros 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever In U Armed Forces? 1 1⊋ Yes 2 ☐ No it Yes, Give Year or Dates:		21090 Ident of Hispanic Origin? (S Icify Cuben, Mexican, Puerl 如 No Specify:	pecify Yes or No- o Rican, etc.)	U • S 14. Raca - Amer Bleck, White Specify: W)	
deal Ex	15. Decedent's Ed (Specify only highest gra	lucation	16a. Decedent's Usu	al Occupation ork done during most of wor	kina 1	6b. Kind of Business/li	ndustry
then then	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u	ent Mechani		.S Coast	Yard
d other event, n	17. Fether'a Name (First, Middle, Last)				ne (First, Middle, M		
7 is marked othe traumatic event, To Be C	John Tomaszews	ki		Stella	Brach		
and a man	19a. Informant's Name/Relationship (s (Street and Number or Ru			ip Code)
- N -	Sandy Conrad/			rd St. Bal			
	20a. Method of Disposition	Removal from State	Place of Disposition (Ne cemetery, crematory or	other plece)		Oc. Location - City or T	
- E	4 □ Donation 5 □ Other (Special) 21 Signature of Funeral Service Licen		edar Hill	4 4 4 4 4 4 4 4 5 4 5 4 5 4 5 4 5 4 5 4		altimore	
Depa Impo eny li pnce	21. Signature of Potneral Service Licen	Ly				neral Hor	
	23a. Part1. Enter the disease, or poor shock, or heart failure. List only	licationa that caused the dea	th. Do not enter the mo	Ritchie Hw de of dying, such as cardia	y Balt or respiratory arre	o. Md. 2	Approximete
nysician	shock, or heart failure. Listony						Onset and Deeth
Medical	Immediete Ceuse (Final disease or condition	Cardi	ac Are	hythmia			8 minutes
aminer	resulting In death)	Due to (or es e consequence of)	In Farcho	•		
nine nine		b. Myoc	ardial.	In tarcho	1	1	5 minutes
lcian end burial-transit al Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events		or as a consequenca of)				70 years
Dur Se	Cause (Disease or Injury that initiated events	c. COPO	or as a consequence of).	very 1113	ease	1	o- years
0 0	resulting in death) Last	· Diahe	1	11/hus			
of or use		d	1.0	77 00			
ched ched	Part II. Other significant conditiona co	ontributing to death but not re	sulting in the underlying	cause given In Part I.			to the cause of death?
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should should					24a. Was an perform	ed?	Vere autopsy findings iveilable prior to completion of cause of deeth?
irector, page 2 s lirector, page 2 s o Be Compi					1 □ Ye	s 2000 1	□ Yes 200No
certificate ha rector, page Be Com	25. Wes case referred to medical examiner?				eth (Check only one)	
Piss P	1 ☐ Yes 22 ANo		₽R/Outpatient 3□ D			nce 6 Other (Spec	city)
	27. Manner of Death 1 Seturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)		28c. Injury at Work?	28d. Describe ho	w Injury occurred	
the f	2 Accident Investigation 3 Sulcide 6 Could not be		M M	1 Yes 2 No	28f Location /Co	eet and Number or Ru	ral Route Number
Direct in by	4 Homicide determined	28e. Placa of Injury - At I building, etc. (Spec	ify)	у, опісе	City or Town,		rei Houte Number,
To the Funeral Director: After to completely filled in by the funeral Medical Certification:		ysician: To the best of my kn ilner: On the basia of examin and manner stated.					
Within 24 hours after dear To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of cartifler	and marrier states.	29	c. License number	29	d. Date signed (Month	n, Dey, Year)
- 0	1 Alther Mil	huransed	1	0005202	2 0	august 2	7,1999
\supset	30. Name and address of pegson who	completed cause of death (Ite	m,23a) (Type, Print)	2005202 South 1/a			14.
	Kobert M.	- Yacynya	9001	South Ita	nover SI	REET, BU	Marce Md.
State	31. Date filed (Month, Dey, Year)	99 32 Figistrar's Sign	eture 4	20. 1.1			



			Certificate of D	ealth and Mental F Death	Reg. No.	61406
Physician /Medical	1. Decedent's Neme (First, Middle, Last) WILLIAM R.	WES		2. Dete of Amonth Aug.	ust 29 1	Year 4 18 AM
Examiner	4e Fecility Neme (If not institution, give street and number FRANK LIN SOUARE	HOSPITA	al center [RUSEDALR	BALT	THORE
uneral irector	5. Social Sacurity Number 6. Sex 1 ⋈ M 2 □ F 7 214-01-9886 Usuel Residence of Decedant	Age (In yrs. lest birt	rs. Months Deys	Hours Min. (Month,	Birth Dey, Year)	9. Birthplace (State or Foreig Country) Md.
sa-f show tiffed at	Md. Baltimore	10c. City, Town	or Location arkville			10d. Inside City Limit
st be no at be no al Dire	10e. Street and Number 8820 Walther Blvd. #4107		10f. Zip Code 21	.234	10g. Citizen of Wi	nat Country?
*natural", or items 23a or 28a-f ehow edical Examiner must be notified at leted by Funeral Director	11. Maritel Stetus 1 Never Merried 2 Merried 3 XWidowed 4 Divorced 12. Was Deceder Armed Force 1 Xeyes 2 If Yes, Give Year or Deter	s?	13. Wes Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☐ No	penic Orlgin? (Specify Yes or , Mexican, Puerto Rican, etc.) Specify:	Bleck Specify:	- American Indian, , White, etc. White
d other than "nature event, the Medical I Be Completed	15. Decedent's Education (Specify only highest grade completed)	16e.	Decedent's Usuel Occupet (Give kind of work done du lifa. DO NOT use retired)	ion uring most of working	16b. Kind of Bus	
Comp	Elementery/Secondary (0-12) College (1-4c)		ersonnel		Telephon	
arked oth	17. Fether's Neme (First, Middle, Last) William H.	West		18. Mothar's Neme (First, Mid Charlotte Ja		
aumet	19a. Informant's Name/Ralationship (Type, Print)	19b.	Meiling Addrass (Street at	nd Number or Rural Route Nu	mber, City or Town, S	State, Zip Code)
em 27 rther tr	Mr. Robert West/son 20e. Method of Disposition	20b. Piece of	Disposition (Neme of	Ct. Ellicott	7	21042 City or Town, Stete
ry or o	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from Ste 4 ☐ Donetion 5 ☐ Other (Specify)	te	on Forest Vet	1		Mills, MD.
Important: If hen 27 is merked orby than eny injury or other traumatic event, tra He once. To Be Compl	21. Signature of Funerel Service Lice)	22. Name end Address Ruck Towso	on Funeral Hom Rd. Towson, Md	e, Inc.	,
	23e. Pert1. Enter tha diseese, or complications that ceus shock, or heart failure. List only one ceuse on each	sed the deeth. Do n n iina.				Approximete Intarval Batween Onset end Death
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sit	CHRO	MIC OBS	TRUCTIVE	PULMONARY	DISEASE	
ng physician and as the bunal-transit	Sequentielly list conditions, it eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated evants resulting in deeth) Lest	Due to (or as a c				
attending physics to the set as the clan/Medic	d					
detached detached Physi	Part II. Other significant conditions contributing to death RENAL FAILURE	h but not resulting in	the undarlying ceuse give			ribute to the cause of deat 3 Probably 4 Unkno
should should	PERIPHERAL VAS	Scular	DISEASE	24e. V	Ves an eutopsy erformed?	24b. Were autopsy findings available prior to completion of cause of deeth?
certificata has frector, page 2 Be Comp	DIABETES MELL	ITUS		1	□Yes 20M6	1 Yes 2 No
irector o Be	25. Wes cese raterred to madicel axeminer? 1 ☐ Yes 2☑ No Hospital: 1 ☐ Impa	atient 2 ER/Ou	tpetient 3 DOA Otha	26. Place of Death (Check or 1. 4 □ Nursing Home 5 □ F		(Specify)
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	27. Menner of Deeth 1 Defatural 5 Pending (Month, I	njury 28b. T	ime of 28c. Injury Work		be how injury occurre	
Direct d in by t	3 ☐ Suicide 6 ☐ Could not be determined 28e. Piece of building.	injury - At home, far etc. (Specify)	m, street, factory, office	28f. Locatio City or	on (Street end Numbe Town, Stete)	r or Rurel Route Number,
Funera etely fille dical C	29a. Cartifiar (Check only one) 1 Certifying Physician: To the be 2 Medical Examinar: On the basis end menner	of examinetion and	daath occurred at tha time	a, data and plece, end due to inlon, deeth occurred et the tir	the ceuse(s) and mar ne, dete end plece, e	nar es steted. nd due to the ceuse(s)
To the	296. Signature and title of ceglier		29c. License	number	29d. Date signed	(Month, Dey, Year)
	1 11011			5010	8/29	7/99
		of death (Itam 23e) (E DRIVE BAL	THORE, HI	ARYLAND 2123
	31. Date tiled (Month, Dey, Year) 32. Regi	istrar's Signatura				



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State

Registrar

31. Date filed (Month, Dey, Year)

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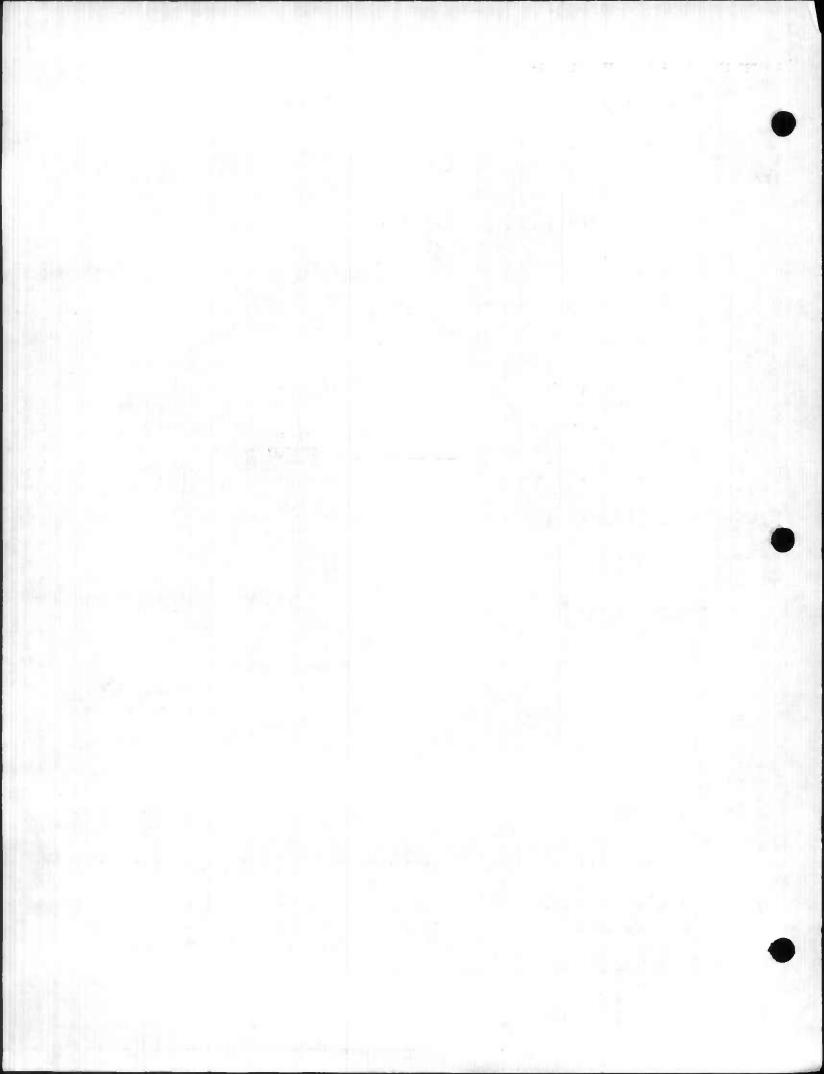
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1999

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Dankers

32. Registrar's Signeture



Phys /Mo Exa

Fune Direct

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certi	ficate	of	Death	2

ene 99 27431

Baitimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryla Hydiana.	Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow
Baitin	Departmen	Important

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificete be associated within 24 hours effect death.

To the Fuhreral Directors. After this cardificate has been signed by the attending physician and completely filled in by the function director, page 2 should be deteched for use as the bursh-transit completely filled in by the function director.

Division of Vital Records, P.O. Box 68760,

						Death			Reg. No.		- 1 1 1 7
Decedent's Nama (First, Middle, La.	st)							2. Data of De Month	eath Day	Yaar	3. Time of Death
IRENE		WARD						AUGUS		1999	9:53 PM
4a Facility Nama (If not institution, giv. BON SECOUR HOSP)		ber)						ocation of Deal	th 4c. Co	ounty of Death N/A	
5. Social Security Number 6. S 217-32-9115	7	. Age (In yrs. 73	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 08/30/		Cou	iplace (Steta or Fore intry)
Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty. Town or Lo	cation							10d. Inside City Lim
					-						1 ☐ Yas 2 ☐ I
MD N/A 10e. Street and Number			BAL	10f. Zip					10a, Citize	n of What Cou	intry?
1938 MOSHER ST.						2121			USA	1	
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15. Decedent's Ed (Specify only highest gra	ducation ada completed)		16a. Dece	kind of wo	rk done	during mos	st of work	ing	16b. Kind	of Business/fi	ndustry
Elementary/Secondary (0-12)	College (1-4	lor 5+)		DO NOT us					77.03	-	
17. Father's Name (First, Middle, Last)				HOMEM	AKER		ar's Nam	a (First, Middle	HOM Maiden Su		
JAMES EDWARD WII	Territoria C. S.							SCOTT			
19a. Informant's Neme/Relationship (19b. Meilie	ng Address	s (Street			ral Routa Numb	per, City or T	own, State. Zi	ip Code)
BETHORIA MARTIN/SI								IMORE,			
20a. Mathod of Disposition 1 El Burial 2 Cremation 3 D		ata	Place of Dispo cematary, crar	natory or o	me of other plac	ce)		Data		tion - City or T	
4 Donation 5 Other (Specify	··	M'	r. CAL			£ 100 141		9/4/99	BALT	TIMOE,	MD.
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State Registrar

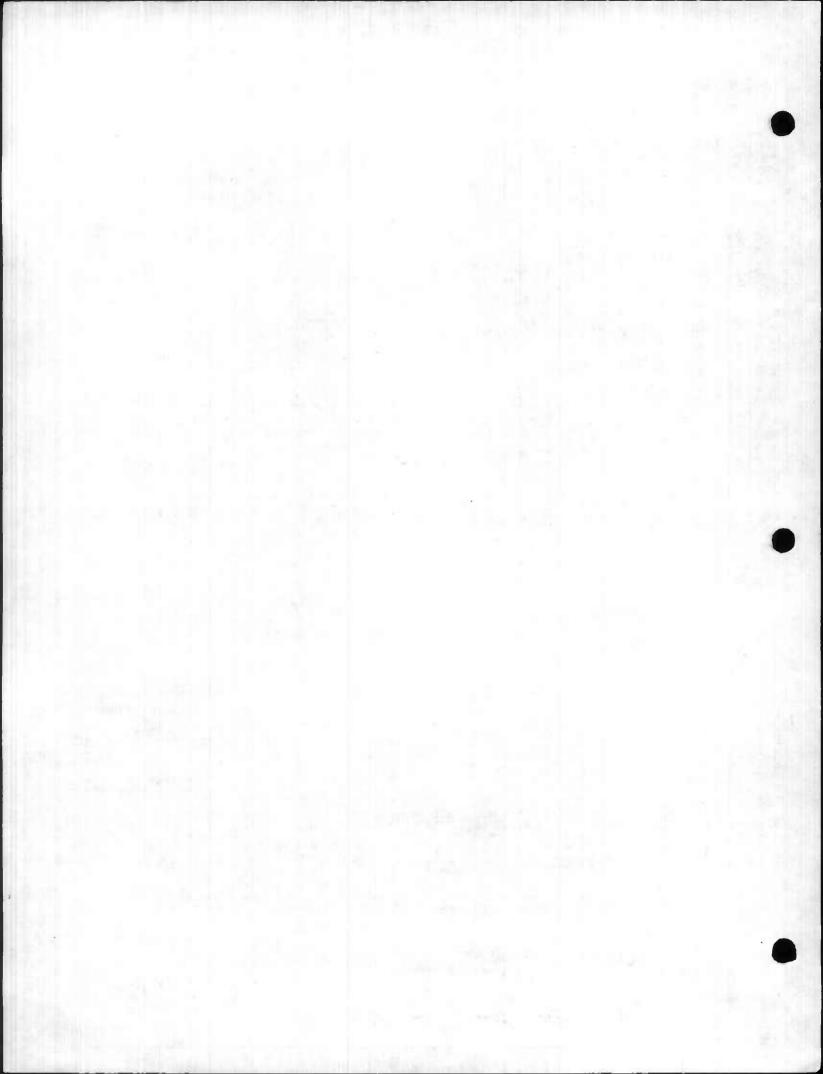
31. Data filed (Month, Day, Year)
SEP 0 1 1999

Margarita Korell M.D.

32. Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201

Belling B. Spouls



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 5:20am 2. Date of Death 4b, City, Town, or Location of Death Epenesis Eldercare If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 108M 2□ F Months 10c, City, Town or Location
Baltimore 10d. Inaide City Limits 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of Whet Country?

13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cubag, Mexican, Puerto Rican, etc.)

Haemondege

122

16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
Maintenance
Maintenance

1 Yes 2 No

12. Was Decedent Ever in U.S. Armed Forces?

1 Yas 2 No
If Yes, Give

Year or Dates

Collega (1-4or 5+)

e, or complications that causad the death. Do not enter List only one cause on each line.

1 Inpatient

28a. Date of Injury (Month, Day Year)

tensum

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Due to (or as a consequence of):

Due to (or as a consequence of):

Funeral Director

Physician /Medical

Examiner

Usual Residence of Decedent

1 Never Married

20a. Method of Disposition 1 Burial 2 Cremation

Immediate Cause (Final disease or condition resulting in deeth)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last

4 Donation

3 Widowed

2 Married

15. Decedent's Education (Specify only highest grade completed)

4 Divorced

Father's Name (First, Middle, Last)

19a. Informant'a Name/Relationship (Type, Print)

5 ☐ Other (Specify)

10a. Stata

death with the Maryland mast be notified at

Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after or and of Healin and Mental Hygiene.
Int: If flem 27 is marked other than natural; or fles ury or other traumate event, the Medical Estampate or other traumate event, the Medical Estampate. Department

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Physician /Medical Examiner

certificate After this

or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: A filled in by To the Hospital

Examiner Be Completed by Physician/Medical

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical axaminer? Medical Certification: To 27. Manner of Deeth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C-V. CYRIAC M.D 8109 RITCH IZ GWY, 31. Date filed (Month, Day, Year) SEP 0 1 1999 State Registrar

29b. Signature and title of certifier

1 Yes 2 No

5 Pending Investigation

6 Could not be determined

1 Matural 2 Accident

3 Suicida

29e. Certifier (Check only one)

4 Homicide

Attending Doeter

D21684

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner stated.

1 ☐ Yea 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

LSA

American Indian.

Black, White, etc.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Aursing Home 5 Residence 6 Other (Specify)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 Yes

PASAORNA

26. Piace of Death (Check only one)

22. Registrar's Signature

The state of the state. ROLET C) 12 - 1 m PARTICIPATION PROPERTY. Established States A STATE OF S The first of the Stort Designation Advantage APRIL A D. D. W. EARLINE sellar 3 syrate Will dentise Day (SEE Stephing and the part of the They are in the stay the south of the Strain the state of the state of the

	Please	Type or Prin	nt In E	llack	(Indelible Ink	Assure A	All Coples	Are L	egible.	
		State of Ma	arylan		epartment of F		Mental Hy	giene Reg. No.	99	27436
1. Decedent's Nar	me (First, Middla, Las	st)		-			2. Data of De			3. Time of Death
AUNIE	. E. W	unte					ALIOLIS!	- Poy	CYC	2000
	(If not Institution, give	a street and number) HOSPII	FAL			6b. City, Town, or BALTI	Location of Death		ounty of Dear	WORE CITO
5. Social Security 219-82-	9350	ex 7. Ag.	a (In yrs. 8	-	hday) If Under t Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year) 14		thplace (Stata or Foreign puntry) yland
Usual Residence	1			- 01						
Md •	Anne Ar	undel	Ba1		or Location ore					10d. Inside City Limits 1 ☐ Yas 2 ☐ No
10e. Street and No 405 Dor	is Ave.				10f. Zip Code 21225			10g. Citize	n of What Co	puntry?
- 11	rried 2 Merried 4 Divorced	12. Was Decedent I Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Give Yeer or Datas:		S.	13. Was Decedent of I- If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yas or No to Rican, etc.)		Race - Ama Black, Whit pecify: Wh	
(Spe	15. Decedent's Ed	ucation da completed)			Decedent's Usual Occup (Giva kind of work done	during most of wo	rking	16b. Kind	of Businass	/Industry
Elementary/Sec 7th		College (1-4or 5	+)		Housewife	9)			Own H	ome
17. Fathar's Nama	(First, Middla, Last)	Charles H	E11i				ma (First, Middle	, Maiden St		
19e. Informent's N	Neme/Ralationship (7	Type, Print)		19b.	Mailing Address (Street	and Number or R	ural Route Numb	er, City or T	own, Stata,	Zip Code)
William	White J	r./Son			5 Doris A		timore	Md.	2122	5
	sposition Cramation 3 5 Other (Specify				Disposition (Nama of c, crematory or other place Hill Cem		Data 8/31		imore	Town, Stata Md •
21. Signatured F	uneral Service Licen	your o			22. Name and Addre	ss of Facility GC	nce Fu	nera	1 Hom	e P.A.

Physician /Medical **Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be axecute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunial-tran

State Registrar

23a. Part 1. Enter the disease or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or haar failure. List only ona cause on aach line. Immedieta Causa (Final disease or condition resulting in death)

1 Yas 2 No

27. Menner of Death

1 Naturat

2 Accidant

3 Suicida

29a. Certifiar (Check only one)

4 Homicide

29b. Signatura and titla of certifian

Director

Funeral

þ

Completed

Be

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If them 27 is marked other than "paturel", or thems 23a or 28a-f show any injury or other traumatic event, the Market St.

Baltimore, Maryland 21215-0020

Sequentially list conditions, any, leading to immadiate ause. Enter Undarlying ause (Disease or Injury act initiated events asulting in death) Last	{

Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I.

25. Was casa rafarred to medicat axaminar?

Hospitel: 28a. Dete of Injury (Month, Dey Year) 5 Pending Invastigation

6 Could not be datamined

1X Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of Injury 28c. tnjury at Work?

Dua to (or es a consequence of)

28e. Piece of Injury - At home, farm, street, factory, office building, atc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Othar (Specify)

28d. Describe how injury occurred 1 Yes 2 No

24a. Was an autopsy performed?

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place; and due to the cause(s) and mannar stated. 29c. License number

30. Nama and adplass of person who completed causa of death (Item 23a) (Type, Print)

23b. Did tobacco use contribute to the cause of death?

1 Yan 2 No 3 Probably 4 Unknown

24b. Wara autopsy findings available prior to completion of causa of death?

1 ☐ Yes 2 No

Approximete intarvel Between Onset and Death

UGWU-DIKE, ND POST INT MEDICINE,

32. Registrar's Signetura

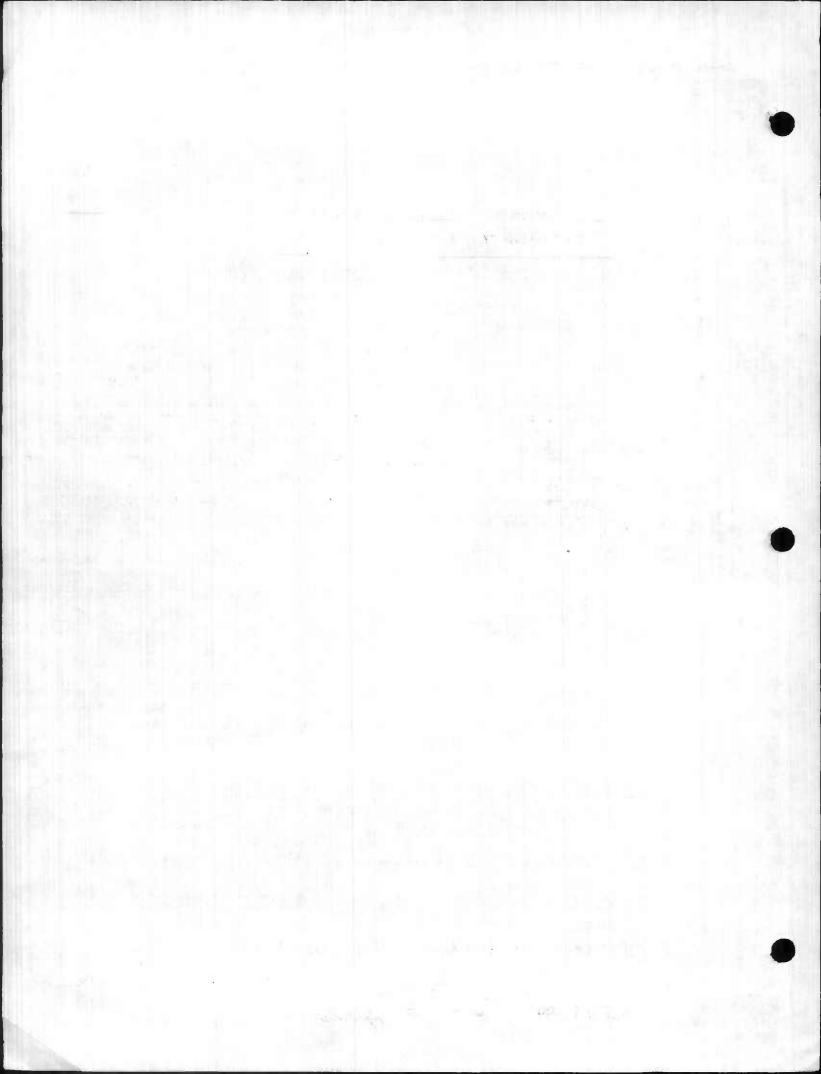
DHMH 16 Ray 6/95

THE PARTY OF PERSON STANDARDS

which is not seen to design

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Amended	Items#10b-f perFH G775 9/1/99 EW Certificate of Death	Reg. No.	99 21431
Physician /Medical	1. Decedent's Neme (First, Middle, Last) JACQUELINE ZRIMEN	2. Dete of Death Month Dey AVU 3	Year 1999 11014
Examiner Funeral	4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Lo. 6601 PANK ITS AVE. APT D - 2 BALTIN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	YON C	9. Birthplace (State or Foreign
Director	218-78-8942 1 M 2 T F 53 Yrs. Months Days Hours Min. Usual Rasidence of Decedent	JAN. 11,194	MOROCCO MOROCCO
rector	10a. Stata 10b. County 10c. City, Town or Location MD N/A Montgomery BALTIMORE. Silver Spring		10d. Inside City Limits
\$ 0.24 D	10e. Street and Number 14203 Treehouse Térrace 10f. Zip Code 20906		on of What Country?
ars after death w if, or items 23s Caminer must. by Funeral	11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forcas? 1 □ Never Married 2 □ Merried 3 □ Widowed 4 ☒ Divorced 12. Wes Decedent Ever in U,S. Armed Forcas? 1 □ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give Yeer or Detes:	ecify Yes or No- Rican, etc.)	S.A. Rece - American Indian, Black, White, etc.
ed within 72 hours or then "neturel t, the Medical E. Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working) Iffe. DO NOT use retired) ELECTROLOGIST	ng	of Business/Industry
Be well		(First, Middle, Maiden St	
nd 2 should ith and Men. 27 is marker r traumatic. To	19a. Informant's Name/Ralationship (Type, Print) DORON NETANEL / SON 19b. Meiling Address (Street and Number or Rura 3207 CARNEGIE HALL CIRC		
Pages 1 an nent of Hea ent: If Item: ary or othe	20e. Method of Disposition 1 XBurial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) CHEVRA AHAVAS CHESED	Dete 20c. Loca	RANDALLSTOWN, MD
Deemit. Departments Imports any inji.	21. Signeture of Funeral Service Lineard 22. Name and Address of Facility 8900 REISTERSTOWN II		& BROS., INC.
bhysician be executed water directed be executed with the same and the same as the burial-transit for use as the burial-transi	23a. Pent1. Enter the diseased or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Causa (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of):	ESSION -	Interval Batween Onset and Death hours -days CZ 1-Zweeks Gyears
the d sy the ached	Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause givan in Pert I.	23b. Did tobacco un	se contribute to the cause of death? Sup 3 Probably 4 Unknown
has been sign ye 2 should be mpleted by		24e. Wes an autops; performed?	available prior to completion of cause of death?
hysician: his certific al director To Be	27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at 2		Other (Specify)
tal or Attending P at Director: After to led in by the funera Certification:	2 Accident investigation M 1 Yas 2 No	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, etc. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, etc.		
	29b. Signeture and title of certifier Eclipson JRee Mb 23601	29d. Dete	signed (Month, Day, Year)
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANCED INSTITUTE SINGL HOSPITAL, 2401 (31. Deta filled (Month, Day, Year) 32. Pegistrer's Signetura	W. BELLED	ERE, BOX TO, MB



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Date of Death 3 Time of Death Month 13 Day 11:58 am George Washington Anderson 4a Facility Nemo et not institution, give street end number) 4b. City, Town, or Location al Death 4c. County of Death Kensington Wexford Drive Montgomery 6. Sax 1 M 2□ F If Under 1 Yaar 9. Birthplaca (Statt or Foraign Country) 7. Aga (In yrs. last birthday) Days 083 16 3305 Usual Residence of Dacedant Yrs Texas 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County washington, Yas 2□ No 10e. Street and Number 10g. Citizan of What Country? USA 7415-9th. N.W. 20012 14. Race - Amarican Indian, Black, White, atc. . Was Dacedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yas, Give 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried 1□ Yas 2 No Specify: Specify: Black 3 ☐ Widowad 4 ☐ Divorced 15. Decedent's Education (Spacify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Minister. 12 YFS. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Surnal Lilly Bookman John Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Same as: Odell D. Anderson (Wife) 10e, C Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata incoln Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signelura of Funeral Service Licensee T. Rhines Co. 23a. Pal1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate Approximate NON HODGEONS LIMPHOMA Immediata Causa (Final disaasa or condition rasulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disease or Injury that Initieted evants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as e consaquence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. * MUSCENOTE 1 Yes 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed? 24b. Wara autopsy findings svallable prior to complation of cause of daath? 1 Yas 2 No 25. Was case referred to medical examinar? 26. Pleca of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1□ Yes 2 No 1 Inpatiant 2 ER/Oulpetien1 3 DOA 27. Manner of Death 28d. Dascribe how Injury occurred Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding investigation 1 Yas 2 No -13-99 2 Accident

attending physicien end for use as the buriel-trans page 2 should

Examiner Physician/Medical þ Completed Be 2 Certification:

Physician

- /Medical

Examiner

Directo

Funeral

py

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at page.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Box 68760. Division of Vital Records. After this Hospital or Attending death. after death 24 hours

State

To the within 2 To the I

31. Data filed (Month, Day, Year)

3 Suicide

29a. Cartifian (Check only one)

4 | Homicida

29b. Signatura and litla of certifier

28e. Place of injury - At homa, farm, streat, factory, office building, atc. (Spacify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Streef and Number or Rural Route Number, City or Town, Steta)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

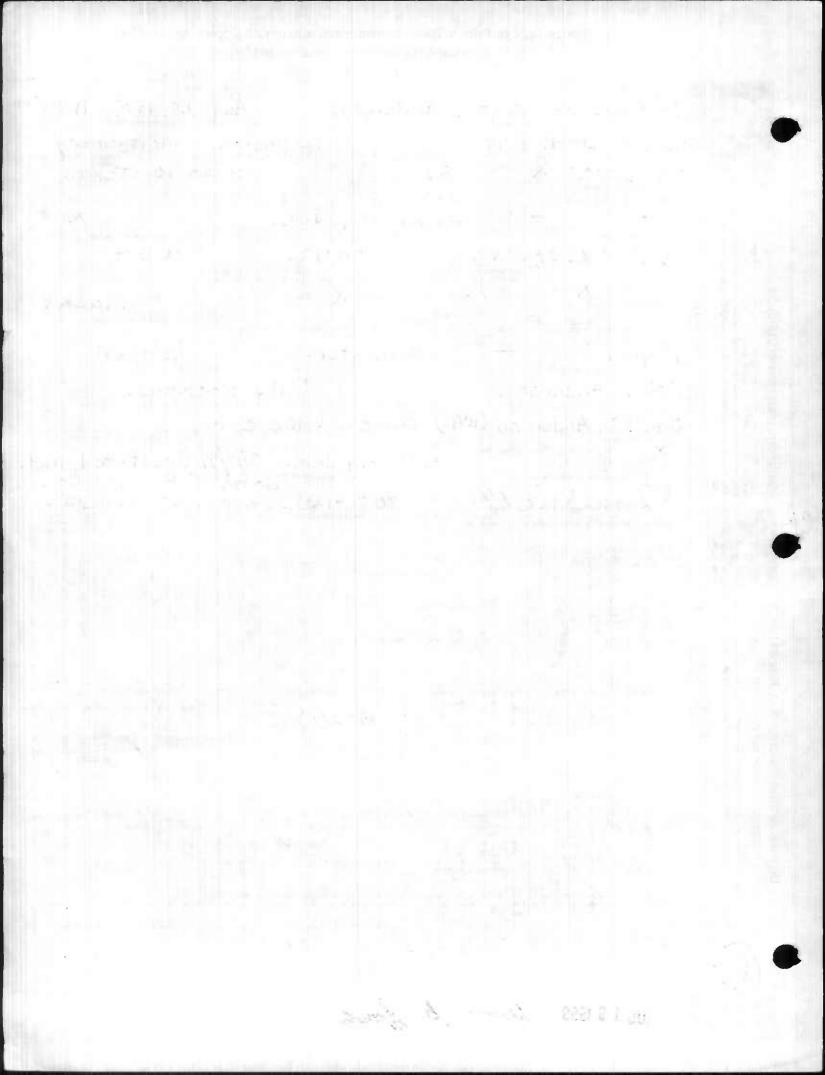
6 Could not be determined

HECTUA (0661500 (C.

32. Ragistrar's Signature AUG 1 9 1999

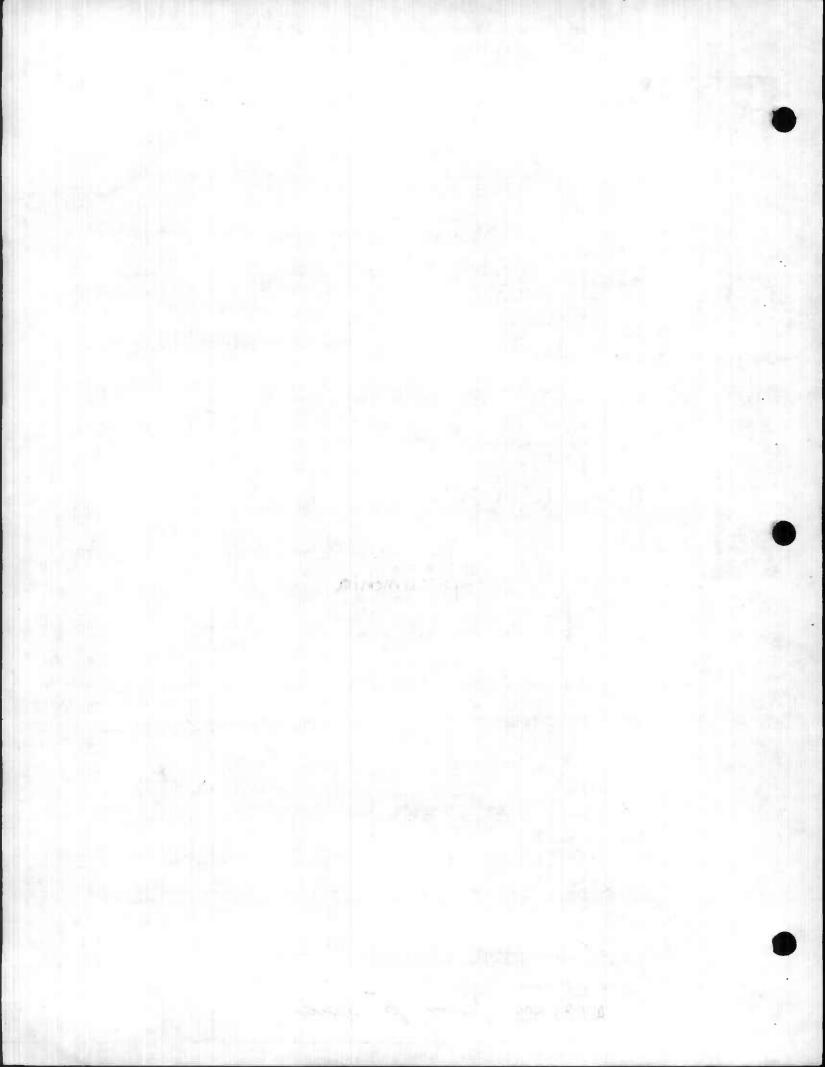
1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

Registrar



Please Type or Print In Black Indelibie ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene

			,	Certifica		Death		Reg. No.	- 6- 1	400
Physician /Medical	1. Decedent's Name (First, Middle, Las	JOHN		MRA	HALL	14	2. Dete of Dec Month	Dey	Year 1999	3. Time of Death
Examiner	4a Facility Name (If not institution, give	street and number)				lb. City, Town, or L		4c. County		
	THE JOHNS HOPKINS	HOSPITAL				BALTIMORE			one)	
Funeral Director	5. Social Security Number 6. Se 576-54-1814	7. Age ((In yrs. last bir 50	Yrs. If Unde Montha	Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 7	th y. Year) , 1949	9. Birthpla Country Hawa:	ce (Stete or Foreig y) L 1
Mand Mand	10a. State 10b. County	1	IOc. City, Town	n or Location					100	d. Inside City Limits
death with the Maryland rms 23s or 28s-f show r mast be notified at neral Director	VA Loudoun		Purce1	lville						1□Yes 2√□No
h tha	10e. Street and Number		10l. Zip Code					10g. Citizen of V	Vhat Country	y?
al D	37563 Hughesville	Road		2	0132			USA		
urs after Mr, or he member by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:				ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Bled Specify	e - Americar ck, White, et Wh:	
72 ho	15. Decedent'a Edi	ucation	18a.	Decedent's Usu	al Occup	ation during most of work f)	ina	16b. Kind of Ba	usiness/Indu	stry
ad within 72 ho lygiens. Nor then "natura it, ma the deal	Elementary/Secondary (0-12)	College (1-4or 5+)) 1				urg			
Con Con		4		Contract	Spe			Insura		
M VOICE	17. Father's Name (First, Middle, Last)					18. Mother'a Nam	- 11-11-11-11-11-11-11-11-11-11-11-11-11		10)	
ahouid marke marke	Harry S. Arakawa			CORE			Shimov			
	19a. Informant'a Name/Relationship (7) Howard K. Halvors					and Number or Rui				
1 and Health am 27 Wher tr	20a. Method of Disposition	Oli		Disposition (Na		ville Roa	Date Purc	20c. Location -		
Pages nent of mt: If it ury or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,)	cemeter	politan	Cre:	matory 8	3/16/99	Alexa		
permit. Departr Importr any inje	21. Signature of Funeral Service Licens	1). W.D.	N			ss of Facility a.I. Home, 96 Purce		, VA		
Coloral Examiner Coloral Examiner Colorad Examiner Colorad Exam	Interchange of the disease, or composition of heart failure. List only of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	6	pula ue to (or as a pne	nonary consequence of) UMON consequence of)	Faile					ntérval Between Onset and Death 5 hug
= 0 = =										the cause of death
							10	Yes 2 No	3 Probe	ably 4 Unknow
2 9N Q								an autopsy med?	avail	e autopsy findings lable prior to pletion of cause eath?
							101	res 2000	10	Yes 20 No
defan: The confidence of the Co. Pe Co.	25. Was case referred to medicat examiner?					26. Place of Dear	th (Check only o	nne)		
2 2 P	1 Yes 25 No 27. Manner of Death 1 NNatural 5 Pending 2 Accident investigation	Hospital: 15 Inpatient 28a. Date of Injury (Month, Day)	28b.]		28c. Injur Wor	4 LI Nursing Ho		dence 6 Oth		
8 등등 E	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, fa (Specify)	rm, street, factor	ry, office		28f. Location (: City or Tox	Street and Numb vn, State)	per or Rural	Route Number,
Hospi Fune In Man		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner the dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.								
Med Med	29b. Signature and title of certain			29	c. Licens			29d. Date signe		
1.17	(1)				RE	3-000		August	14,19	97
40	30. Name and address of office of who c			(Type, Print)	ST	THET, BAL	LTINORE	102	1287	
State Registrar	31. Date filed (Month, Day, Year)	32. Registract		4	Lace	W.)				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 13 ROSE LEE BROOKS 16:24 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel General Hospital Annapolis Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Months 1 M 20 F Yrs 71 January 1,1928 Maryland 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 29 West Washington Street, #406 21401 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas?

1 Yes 2 No If Yas, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No Specify: Specify: Black

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Nama and Addrass of Facility

Housekeeper

20b. Place of Disposition (Neme of cemetery, cremetory or other piece)

Chesapeake Crematory

Usual Residence of Decedent 10a. State ahow Maryland Directo 288-1 10e. Street and Number hems 23s or Funeral 11. Marital Status

Physician

/Medical

Examiner

Funeral

Director

5. Social Security Number

218-36-7743

10b. County

15. Decedent's Education (Specify only highest grade completed)

Virginia Lee Scrivner /Cousin

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

College (1-4or 5+)

1 Never Married 2 Married

3 ₩idowed 4 Divorced

Elementary/Secondary (0-12)

8th

(Unknown)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

"natural", or ž Completed Be

72 hours after d 2 should be the off and Mental F Pages 1 and 2 should Department of Health ar Important: If Nem 27 is any injury or other trau

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Box 68760 edicai Physician/M Records, P.O. þ Completed Division of Vital 8 P shis After for Attending F siter death. Director: After

Examiner physician and the burial-transit that the death certificate be executed Certification: hours a Hospital 24 hours Puneral within 2. To the I

J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finel disease or condition resulting in death) FULMINANT PANCREATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): CHRONIC LUNG DISEASE HYPOTENSION SEVERE METABOLIC SEVERE 25. Was case referred to medical examiner? Hospital: 1 Inpatient 1 Yas 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide 29e. Certifier Medical (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 tonknown - RESPIRATORY FAILURE I SEVERE 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No AC100515 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sprtifier MOMPH

State Registrar

CLANCE . Registrar's Signature

038320

180 ADMINAL COCHRANE DR ANNAPOLISMO 21401

16b. Kind of Business/Industry

Private

20c. Location - City or Town, Stata

Beltsville, Maryland

Approximate Interval Between Onset end Death

30AYS

18 Mother's Neme (First Middle Meiden Sumame)

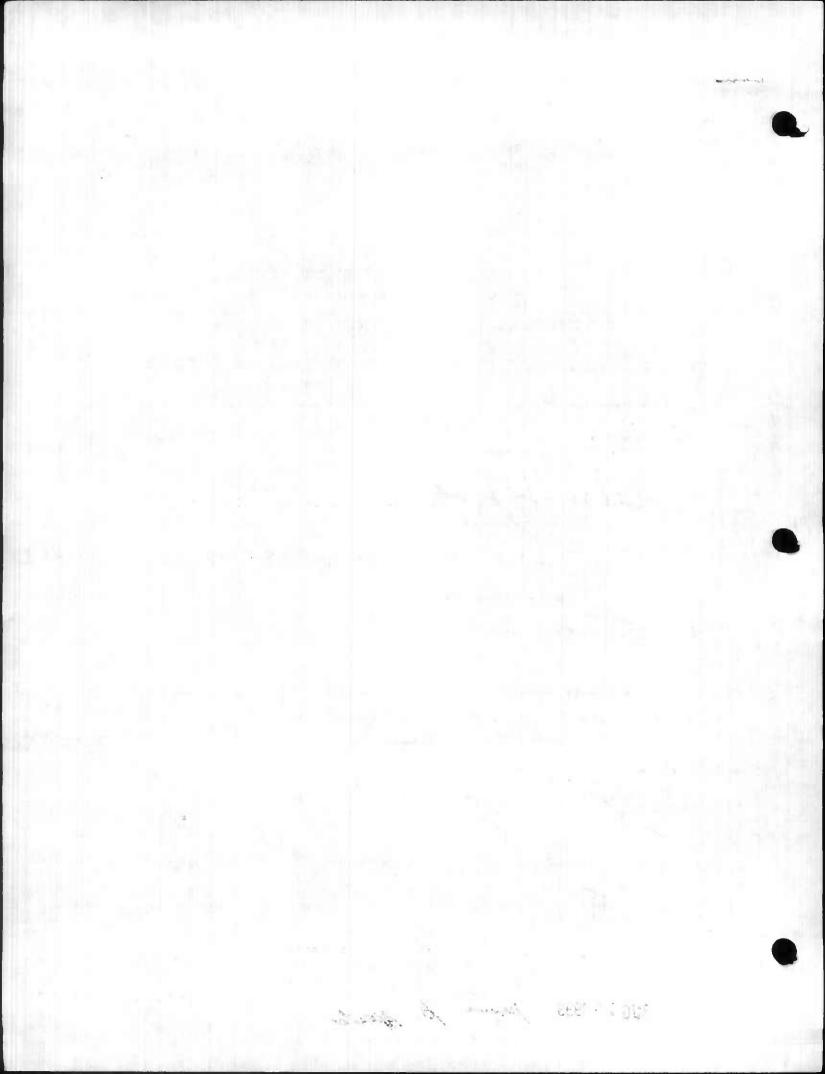
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1999

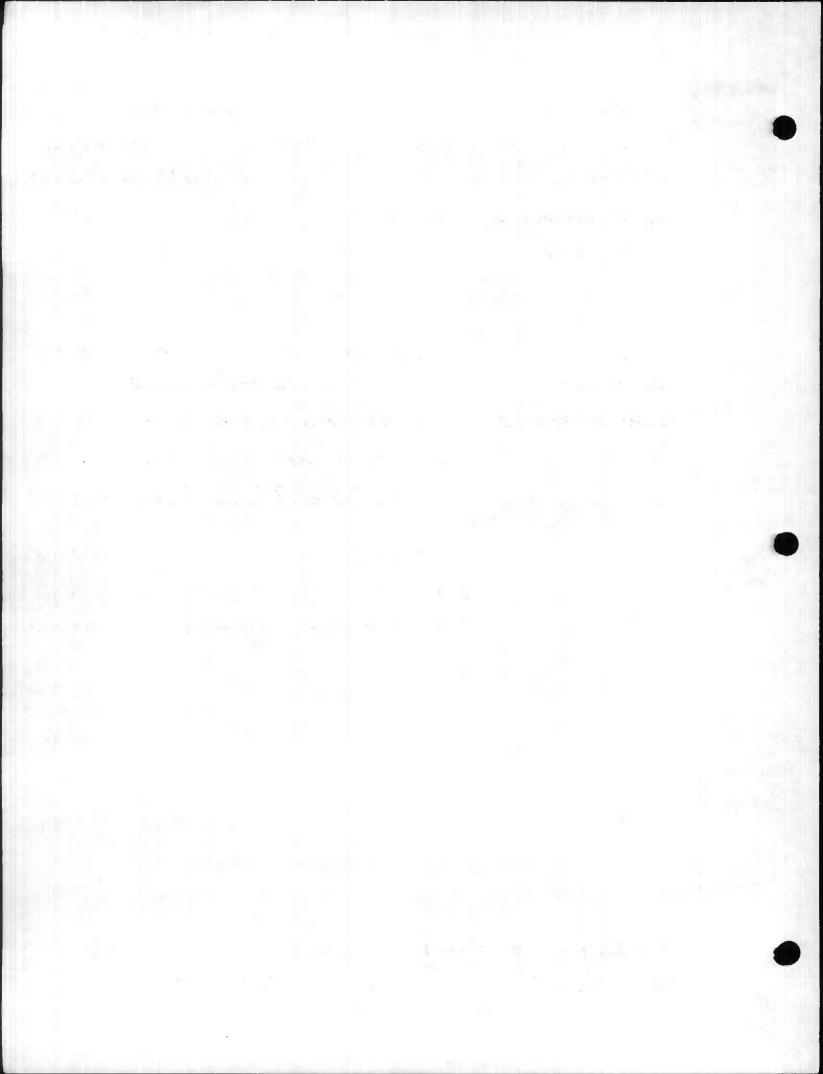
Mary Jackson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1821 Dutch Village Drive, Landover, Maryland 20785

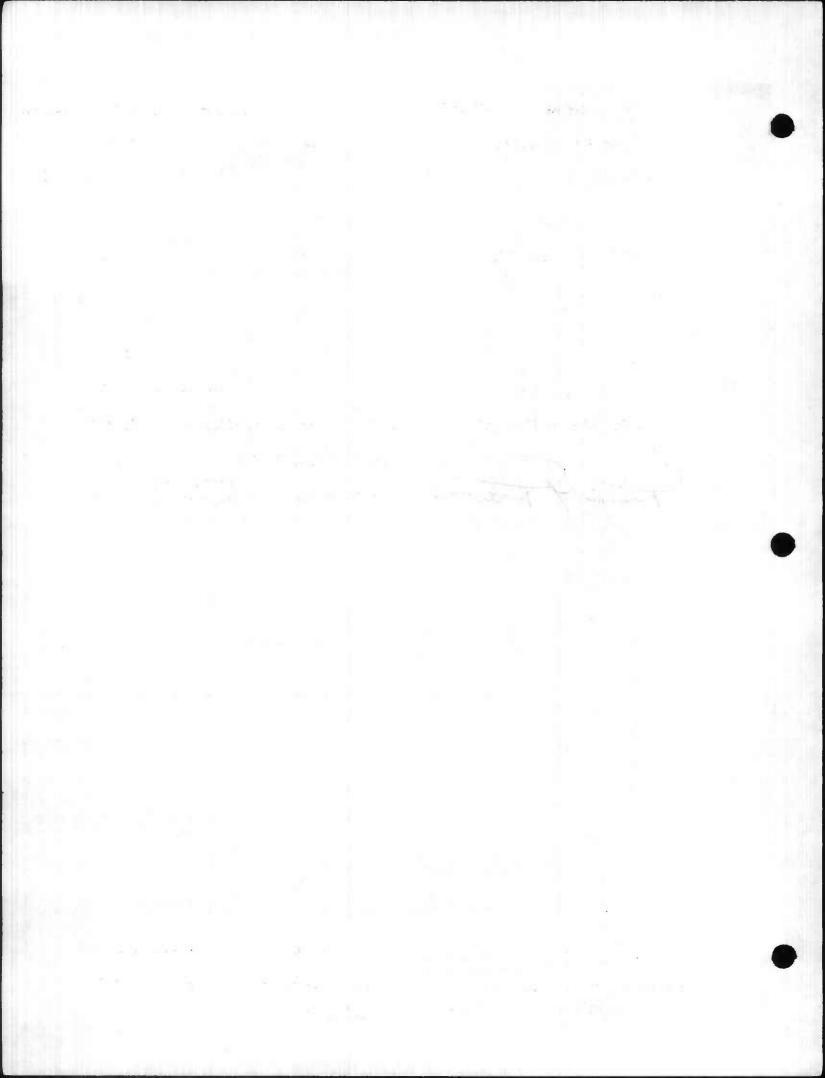


_				i wai yiai i		tificate of	Death		Reg. No.	1 2	1441	
П	Physic	an	Decedent's Name (First, Middle, Last)					2. Data of Dee Month	oth Dev	Year	3. Time of Deeth	
	/Medi		Paul Maydew Brown					August	15 199		4:50 PM	
	Exami		4e. Fecility Neme (If not institution, give street end nu	m <i>ber)</i>			4b. City, Town, or L		4c. County	of Death		
10.	Funeral Director		Western Maryland Hospi 5. Social Sacurity Number 214-09-2220 6. Sex 1 □ SM 2 □ F	7. Age (In yrs.		If Under 1 Yeer Months Deys	Hagerste If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De)	Year)	9. Birthple Country	County ce (State or Foreign y) Virginia	
	D.		Usuel Residence of Decedent							II COC	virginia	
	a-f ahow	ctor	Maryland Washington Co		y, Town or Loc gerstov					100	d. Inside City Limits 1 X Yes 2 No	
	th with the 23a or 28	ai Dire	10e. Street end Number 565 Salem Avenue			10f. Zip Code 21740			USA	Whet Countr	y?	
020	filed within 72 hours after death with the Maryland Hygiene. drher then "neturel", or ferms 23a or 28a-f show ont, the Medical Exeminet must be not the dat	by Funeral Director	11. Meritel Status 1 Naver Married 2 Marriad 3 Widowed 4 Divorced 12. Was Dec Armed F. 1 Tyes, Gir	2 □ No ve		/as Decedent of H Yes, specify Cube	lispenic Orlgin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - American indien, Bieck, White, atc. Specify: White		
21215-0020	gas 1 and 2 should be filed within 72 ho to f Heelth and Mantal Lygiana. If item 27 is marked other than "natur or other traumatic event, the Medical	Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D		during most of work d)	ing	16b. Kind of B			
	filed with Hygiana. Wher than	50	8 0		Unite	d States	Navy		Federa	al Gov	ernment	
Maryland	2 should be filed within and Mantal Hygiana. is marked other than raumetic event, the Mantal to	To Be	17. Fether's Name (First, Middle, Last) Mitchell M. Brown				18. Mother's Nam Margai	e (First, Middle, cet B. M		,		
an	2 sho and N is ma		19a. Informant's Name/Reletionship (Type, Print)		19b. Mailin	Address (Street	end Number or Rur	al Route Numbe	r, City or Town,	State, Zip C	Code)	
	Heelth Heelth Iem 27 i		Margaret Ruth Brown/Wife	9	565 S	alem Ave	nue, Hager	stown,	Marylar	nd 217	40	
ore	of He		20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removel from	0	lece of Dispos emetery, crem	ition (Neme of etory or other plea	pe)	Dete	20c. Location -	City or Tow	n, State	
Baltimore,	Pagas mant of H ant: If ite ury or of		4 Donetion 5 Other (Specify)	Sn	nithsbu	rg Crema	tory A	Aug.16	Smithsk	ourg,	Maryland	
Balt	permit. Pagas 1 end Departmant of Heelth Important: if item 27 any Injury or other tr Once.		21. Signature of Funeral Service Licensee		DC 13	Nema and Addre	ss of Facility Fiery Fuern Blyd	neral H	iome rstown	Maryl.	and 21742	
			23e. Pert1. Enter the diseasa, or complications that shock, or head feilure. List only one cause on e	aused the deeth							Approximata interval Between	
	Physician /Medical		Immediate Cause (Final								nterval Between Onset and Death	
	Examiner		Immediate Cause (Final disease or condition resulting In death) Due to (or es e consequence of):									
		Jer.					000-	2011.0	<i>c</i>	i	codonia	
	d d ansit	Examiner	CONCESTIVE HEART FAIURE. Sequentially list conditions, Due to (or es e consequence of):								59495	
o,	an en rial-tr									1	1150 - n. T.1	
x 68760,	certificate be executed ding physician end sa as tha burial-transit	/Medical	Cause (Disease or Injury that Initieted events resulting In deeth) Lest	Due to (or	as e consequ	ence of):	1410 170	CHISTEN			IMONTH	
Вох	aeth cert ettandin I for usa	Physician/M										
P.O.	that the da	hysi	Pert II. Other significant conditions contributing to de	eeth but not resu	ulting in the un	derlying cause giv	en in Pert I.				he cause of death?	
	as that igned b	by PI						101	′es 2□ No	3 Probe	bly 4 Unknown	
Records,	s been s 2 should	Completed b						24e. Was perfor	en eutopsy med?	avail	e eutopsy findings able prior to pletion of cause eath?	
æ	6 - 6	E						1 D Y	es 2 No	1 🗆	Yes 2 No	
ita	ician: Thi cartificate rector, pag	Bec	25. Was case referred to medical				26. Plece of Deet	h (Check only o	18)			
of Vital	G is X	To	exeminer? 1 Yas 2 No Hospital:	npatient 2	ER/Outpatient	3□ DOA Oth	05	me 5 Rasid		er (Specify)		
ion o	nding Ph ath. r: After thi a funaral		27. Manner of Death 28a. Date		28b. Time of Injury	28c. injur Wor M 1		28d. Describe h			611	
Division	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by tha funa	Certification:		of Injury - At ho ng, etc. (Specify		et, fectory, offica		28f. Location (S City or Tow	treet end Num t n, Stete)	per or Rural i	Routa Number,	
	To the Hospital or Atte within 24 hours after da To the Funeral Directo complately filled in by th	edicai C	29a. Certifier (Check only one) Certifying Phyelcian: To the burner: On the burner and menion and	best of my know asis of examinat her steted.	wledge, death ion end/or Inve	occurred et the tin estigation, in my o	ne, dete end plece, plnion, deeth occur	end due to the dred et the time, d	euse(s) and me date end placa,	enner es ste and due to t	ted. he ceuse(s)	
	To the within 2 To the comple	Me	29b. Signeture end title of certifier	.c. ototou.	4	29c. Licens	e number		29d. Date signe	d (Month, D	ay, Year)	
	F ≯ F ŏ	1. Hanslay a hall masslai										
5			30. Name end eddress of person who completed caus				נשכ ניי			5.99	,	
	Sta	te	36 8 MILLS STATE 31. Dete filed (Month, Dey, Year) 32. R	ET H	HACE E	Apare	W MI	0 2	1740			
	Registr		AUG 1 6 1999	Japana	B.	Some	1					

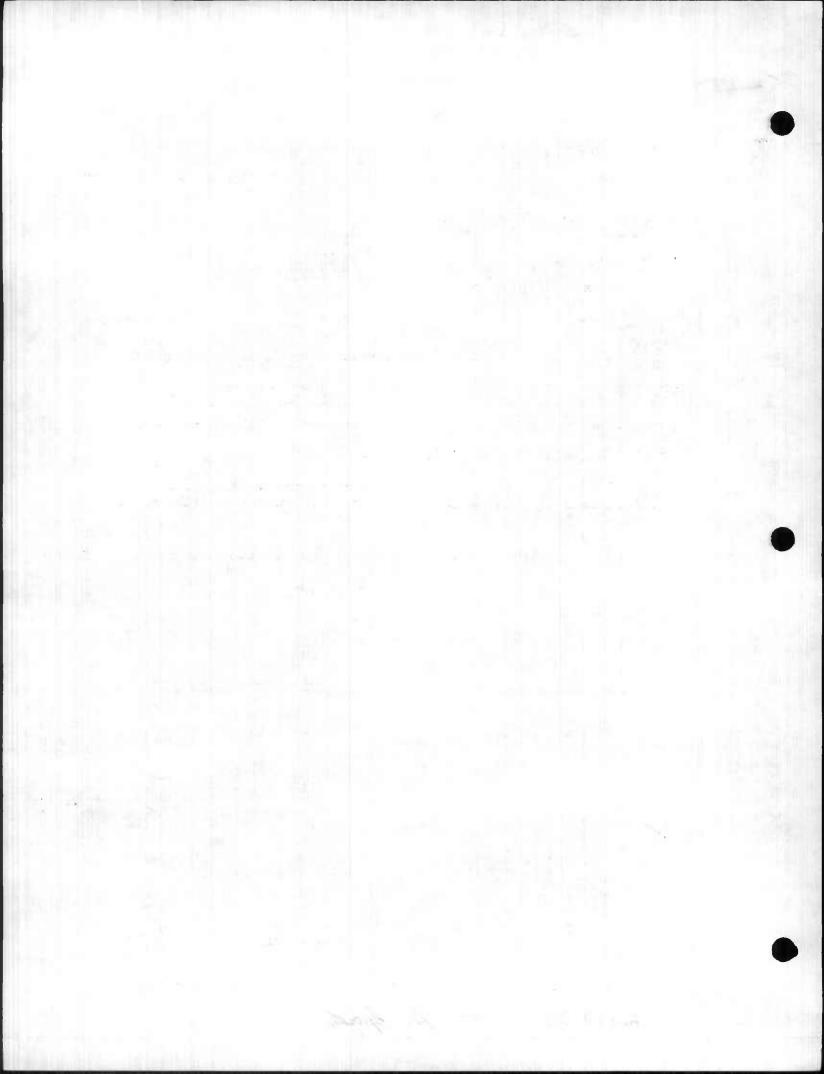


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

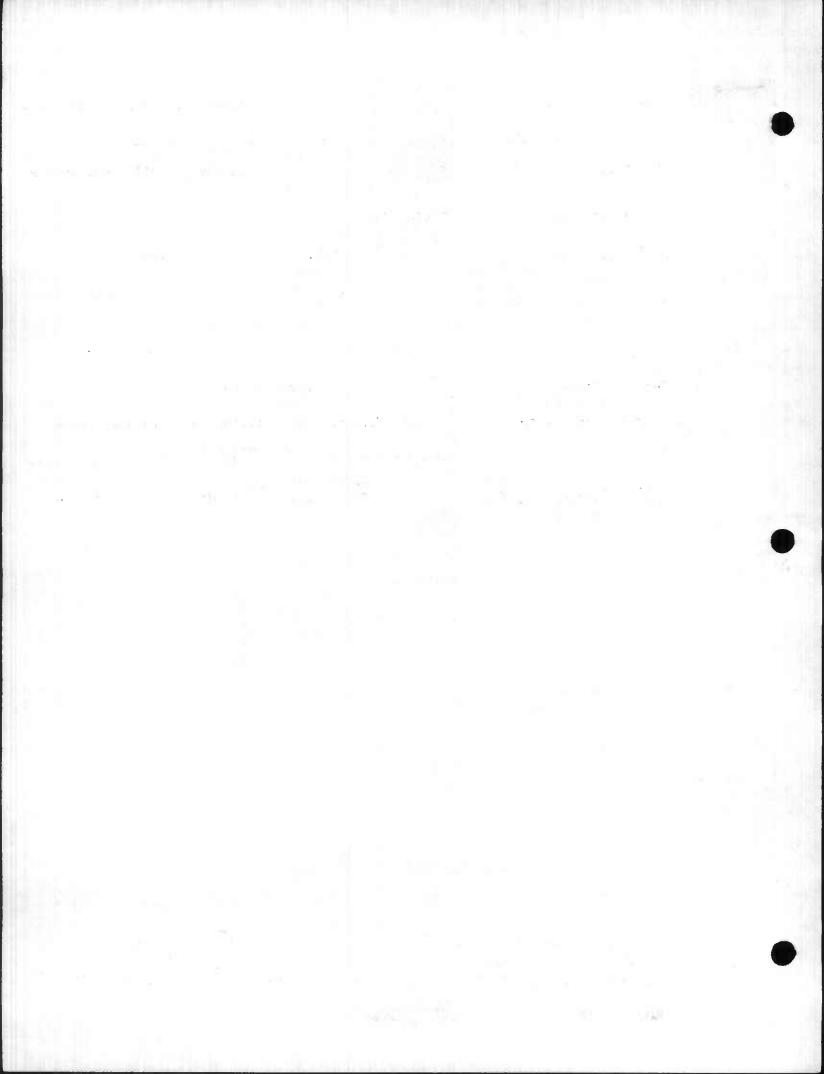
				Otato of mar		Certificate of			eg. No.		
	riteria.	19	1. Decedent's Nama (First, Middla, Las	t)				2. Data of Deat	h		3. Time of Death
	Physici		KRISTY Lynn	BUHR	MAN			Month	Day 15. 1	Yaar 999	9:45 Åm
	/Medic Examir		4a. Facility Nama (If not institution, giva	street and number)			4b. City, Town, or L	the same of the sa	4c. County		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
			Washington Co. Ho	spital			Hagerstov	<i>i</i> n	Was	hingto	on
	Funeral		5. Social Security Number 6 Se	x 7 Age /	In yrs. last birth	day) If Undar 1 Yaar	If Under 24 Hrs.		V	9. Birthpla	ce (Stata or Foraign
	Director		214-08-6056 Usual Rasidance of Dacedant	□M 2KIF 1	6 Y	Months Days	Houra Min.	8. Data of Birth (Month, Day, Oct. 22,	1982	Penns	ylvania
	A ti		10a. State 10b. County	1	0c. City, Town	or Location				100	d. Insida City Limits
	Mary	ō	Md. Washi	ngton	S	abillasvil	lo				1 □ Yaa 2 ☑ No
	150 128	5	10e. Street and Number	3		10f. Zip Coda		10	Og. Citizan of V	Vhat Country	v?
	th with	a Di	24922 Raven Ro	ck Rd.			1780			U.S.A	
Maryland 21215-0020	2 should be filed within 72 hours after death with the Maryland end Mentel Hygiene. Is marked other than "natural", or items 23s or 28s-4 show raumatic event, the Medical Expresser must be notified at	Completed by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Even Armed Forcas? 1 Yas 2 No If Yes, Giva Yaar or Datas:	ar in U,S.	13. Was Decedant of If Yas, specify Cub		ecify Yas or No- Rican, atc.)		e - Amaricar k, Whita, at	
5-0	72 ho	ted	15. Decedant's Edi (Specify only highast grad	ucation	16a. [Decedent's Usual Occu	pation	ring	16b. Kind of Bu	sinass/Indu	stry
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pu	d 2 should be filed th end Mentei Hyg 7 Is marked other traumatic event,	Be (17. Fathar's Nama (First, Middla, Last)				18. Mothar's Nam				
yla	Went Ment Ment Ment Mice	To	Roger D. Bu	hrman				Kimbra L	. Start	uper	
a	end end		19e. Informant's Name/Ratationship (T	ype, Print)	19b.	Meiling Addrass (Stree	t and Number or Rui	ral Routa Number,	City or Town,	Stata, Zip C	(ode)
	and salth		Roger D. Buhrman			22 Raven R		abillas v	ille, Mo	1. 217	80
ore	of Ha		20a. Method of Disposition 1 X Burial 2 □ Cramation 3 □	Demonstran State	20b. Place of i	Disposition (Nama of , crematory or other pla	ice)	Data :	20c. Location -	City or Town	n, Stata
Ĕ	Pag nent int: If		Donation 5 Other (Specify,	Deminar Tolli Stata	Bethel	Cemetery	Aug. 19, 19	99	Cascac	le, Md.	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: if Itam 27 I any Injury or other tra 90.08.		1. Signature of Funeral Service Ident	100		22. Nama and Addre		12525	Bradbur	II Aug	
m	88558		Francis X.	Nav	0	Davis Fu	neral Hom	e Smiths	bura. Ma	1. 217	83
			23a. Part1. Enter tha disaasa, or comp shock, or heert feilura. List only o	lications thet caused the cause on a ach lina.	a death. Do no	ot entar tha moda of dy	ing, such as cardiac	or respiratory arre	est,	1	Approximata ntarval Between Onsat and Death
1	Physician /Medical		Immediate Cause (Finat diseasa or condition	Massive	Closed	Head Inju	ry				6½ hours
	Examiner		resulting In death)	Di.	e to (or as a co	onsequance of):			_		
	D #	iner	_							ĺ	
	ifficete be executed g physicien and as the bunal-trensit	Examiner	Sequentially list conditions,	Du	a to (or as a co	onsequance of):					
Ö,	e exe		Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Diseese or Injury							1	
68760,	ate b hysic the b	edical	that initiated evants resulting in death) Last	C. Du	a to (or as a co	nsequance of):					
	± 0 €									t	
Box	the deeth certifi y the attending a sched for use as	Physician/N		d							
	he at	SIC	Part It. Other significant conditions co	ntributing to death but r	not resulting in	tha undarlying causa gi	ven in Part I.	23b. Did to	bacco use co	ntribute to t	the cause of death?
P.0		Phy						1 🗆 Ye	2 No	3 Proba	ibly 4 Unknown
	es the	þ									
Records,	The lew requires that are hes been signed b page 2 should be deta	Completed						24a. Was a perform		avail	e sutopsy findings lable prior to
ec	lew r	ple									pletion of cause sath?
<u> </u>	The lew ate hes page 2	Хоп						1 □ Yø	s 20 No	10	Yas 2□ No
Vital	ysician: The scorificate director, pag	Be (25. Was casa referred to medicat				26. Place of Deal	th (Check only on	a)		
1	0 0	To	axaminar? 1∭ Yas 2□ No	Hospital: 1 ☑ Inpatiant	2 ER/Out	patient 3 DOA	har: 4 Nursing Ho	oma 5 Rasida	ince 8 DOth	ar (Specify)	
Jo L	D 0 0		27. Mannar of Death	28a. Data of Injury (Month, Day Y	28b. Ti	ma of 28c. Inju	ry at	28d. Dascribe ho	w Injury occur	red	
Division	al or Attending s after death. I Director: After d in by the fune	atic	1 □ Natural 5 □ Panding 2 ◯ XAccident Invastigation	August 14,19			Yas 2 X No	motorcycle	acciden	t - thr	rown off
Vis	Atte ecto by th	tfic	3 ☐ Sulcida 6 ☐ Coutd not be datarmined		- At homa, fam	n, street, factory, office		28f. Location (St. City or Town	reef and Numb	er or Rural I	Routa Number,
ō	s after so and s	Certification:				lle Rd Freder	rick Co.	Foxville		lerick	
building, atc. (Specify) on roadway – Foxville Rd Frederick Co. Foxville Rd Frederick on roadway – Foxville Rd Frederick Co. Foxville Rd Frederick 29e. Cartifiar (Check only one) 29e. Cartifiar (Check only one) 29b. Signatura and lifte of certifiar 29c. Licansa number 29d. Data aigned (Month)						deeth occurred at tha ti or investigation, in my	curred at the time, date and piece, and due to the cause(s) and manner as stated.				
						d (Month. De	ay, Year)				
	F ≥ F 8		506								
			(deval) Diffe	Den		01062	A	ugust I	0, 15	<i></i>
			30. Nema and address of person who o				oner U-	corctor	MD 3	21740	
			Edward W. Ditto, I			I. Washingt	onsi. na	gerstown	, FID 2	21740	
	Sta	te	31. Data filed (Month, Day, Year)	32. Registrar's	Signature	4 /	1				



1. Decedent's Nema (First, Middle, L	ast)	Certificat	e of L		2. Dete of Deet	ng. No.	3. Time of De			
					Month	Dey Y	fear			
Helen Louise Bai					August :	17, 1999	0920			
4a Facility Neme (If not institution, gr	ive street and number)		4	b. City, Town, or Loc	ation of Death	4c. County of	Death			
56 Sarah Drive				Elkton		Cecil				
		. last birthday) If Under Months	1 Year Deys		8. Date of Birth (Month, Day,		9. Birthplace (State or F Country)			
214-56-9390	1□M 2X F 48		Doys	TATE OF THE PARTY	per 26.	3.6	aryland			
Usual Residence of Decedent				Moveiiii	16T 50*	1950				
10a. State 10b. County	10c. C	city, Town or Location					10d. Inside City			
Maryland Cooks	77.1					1 XYes 2				
Maryland Cecil 10e. Street and Number	ETK	ton	0-4-		14	0- 00	-101-0			
Toe. Street and Number		10f. Zip	Cooe			0g. Citizen of Wh	at Country?			
41 Barksdale Cou	irt		2192	1	1	United S	States			
11. Meritei Stetus	12. Wes Decedent Ever in I Armed Forcas?	es Decedent Ever in U.S. 13. Wes Decedent of Hispania			ity Yas or No-		American Indian, White, etc.			
1 Nevar Married 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 ◯XNo						verme, etc.			
3 Widowed 4 Divorced	If Yes, Give Year or Detes:	1 LI Yes	1 ☐ Yes 2 🛣 No			Specify:	White			
15. Decedent's E	Education	16a. Decedent's Usua	Decedent's Usuel Occupation			16b. Kind of Bush	ness/Industry			
(Specify only highast gi	rade completed)	(Giva kind of wo	rk done d	luring most of workin	9					
Elementery/Secondery (0-12)	College (1-4or 5+)									
17. Father's Neme (First, Middle, Las	4	Registere	a Nu			Hospital				
17. Father's Neme (First, Middle, Las	:1)			18. Mother's Neme	(r-irst, Middle, N	naiden Sumeme)				
Fred Thomas Blev	ins			Betty Mon	cetz					
19e. Informent's Neme/Reletionship	(Type, Print)	19b. Mailing Address	(Street a	nd Number or Rural	Routa Number,	City or Town, St	tata, Zip Code)			
Larry D. Baines/	huchand	Al Barked	270	Court, Ell	cton M:	backva	21021			
20a. Method of Disposition		Plece of Disposition (Nat		COULC, EL			ity or Town, Stete			
1 Surial 2 □ Cremation 3	G- 11	cemetery, crametory or o		9)			.,			
4 Donation 5 Other (Special		morial Park		8,	/20/99 1	Elkton,	Maryland			
21. Signature of Funarai Sarvice Lice		22. Nama ar	nd Addras			_				
	0 1 0 -			for Funer	•					
David,	2. Auson						ryland 219			
23a. Part1. Enter the disease, or cor ahock, or heart feiture. List only	y one cause on each line.	ath. Do not enter the mod	ie oi dynn	J, Soci es cardiac or	respiretory erre	381,	Approximete Interval Between			
							Onset and Dec			
Immediate Cause (Finel disease or condition Mestastatu Canangna to lunes and brings 3 mo										
Immediate Cause (Finel disease or condition resulting in deeth) • Metastatu Caramema to lung and lames 3 Due to (or es a consequence of):										
- Caramena of Roeast										
Consession for the desired	D.	(or as a consequence of):	57 000	AD I						
Sequentially list conditions, if any, leading to immediate										
Ceuse (Diseese or injury	cause. Enter Underlying Cause (Disease or injury									
that initiated events resulting in deeth) Last	Due to (or es e consequence of):								
	0									
Part II. Other algnificant conditions	contributing to death but not re	sulting in the underlying o	on in Part t	23b. Did to	bacco usa contr	ribute to the cause of				
		outing in the disconying a	acco give			_/	Probably 4□Un			
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					0.45 1004174		24h Mare automorf			
					24a. Wes at		24b. Were eutopsy find available prior to			
					perform	ned?				
4					perform	ned?	completion of cau of death?			
					perform		of death?			
25 Was case referred to medical				26 Disco of David	perform	s 2 100	of death?			
25. Was case referred to medical axaminer?	Hospital:		Othe	26. Place of Deeth	perform 1 □ Ye (Check only on	s 2 10 No	of death?			
axaminer? 1 Yas 2 No		□ ER/Outpetient 3□ DO		or: 4□ Nursing Hom	perform 1 □ Ye (Check only onle 5 □ Reside	e)	of death? 1 Yes 2 No Parent (Specify)Reside:			
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	Exami		4a. Facility Name (If not institution, give	street end numbe	r)			4	b. City, Tow	n, or Loca	ation of Deeth	4c. County	of Death		
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Division	or Al	Certification:	4 ☐ Homicide determined	28a. Piace of in building, e	njury - At hor atc. (Specify,	ma, farm, str	eet, factory, o	office		28	3f. Location (Str City or Town		er or Mura	II HOUIA IN	imber,
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			JAYANTILAL	KAAT	EL	m) 1-	3 Sil	ug e	erly	HVE	2, 21K	tan	m()	219.	21
	Sta	te	31. Dete filed (Month, Day, Year) ALC 2 1 1000 32. Registrar's Signatura												



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BAXTER NAOMI 2:00 AM BREVARD 23, 1999 AUGUST /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner HALL NURSING CENTER CHESTERTOWN KENT MAGNOLIA 7. Age (In yrs. last birthday)

H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. Birthplace (State or Foreign (Month, Day, Year) | 19029. 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Birthplace (Month, Day, Y 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 160 Director 10 7564 Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at KENT MD 1 Yes 2 □ No Director CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MORGNEC ROAD 200 U.S. A 21620 Funerai death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Mantal Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or item 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) RESTAURAUNT STORE MANAGER 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BELL BAXTER NHOL MUR ALICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) CHESTERTOWN, MD RUAD SCHOTTLAND QUAKER BORDLEY 7985 NECK ELLEN 21620 other 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) Dete 1 ■ Burial 2 □ Cremation 3 □ Removal from State Injury or CEMETERY Aug. 25,1999 4 ☐ Donation 5 ☐ Other (Specify) HESTER CHESTERTOWN, MD any in 21. Signature of Funeral Service Licansee 22. Name and Address of Facility 205 GREEN HERON WAY CHESTERTOWN, MD 21 arvi 21620 23a. Part1. Envir the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final and iovasala 10 disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): certificete be exec physician Physician/Medical the Due to (or as a consequence of): 80 980 ò signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other eigntfloant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 has 1 Ves 207No 1 □ Yes 2 □ No certificate Attending Physician: director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2₽No 2 this funerel 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending Natural after death. 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide ò 24 hours a Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1170 36 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Claster town red 2/620 Was hington K RussinD

DHMH 16 Rev 6/95

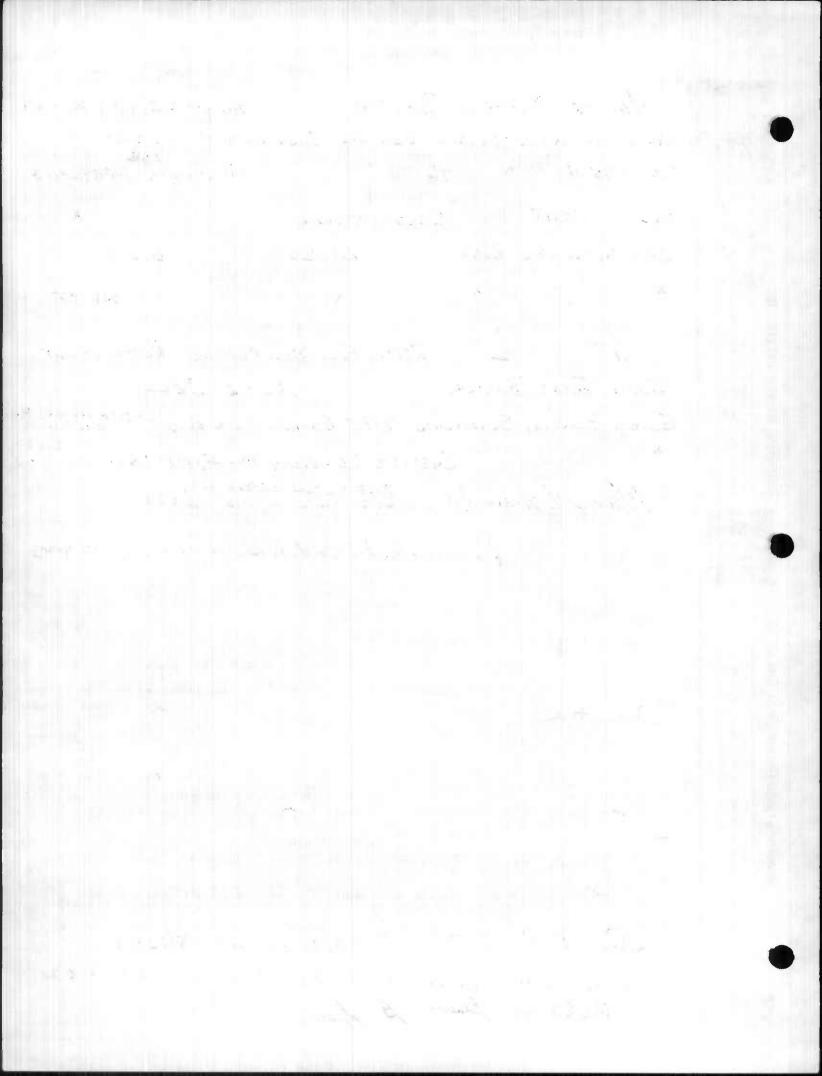
State

Registrar

31. Date filed (Month, Day, Year) AUG 2

32. Registrar's Signature

1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #4c.Per Phys. PGC 8-18-99 hm 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Physician /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death gomes Examiner PRING OSPITAL If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 245-38-279 Usuai Residence of Decedent Ancaster, S.C. Yrs Director 10a. Slala 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show D.C. the Medical Examiner must be notified at 1 Yas 2 100 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 200 200 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? or items 11 Maritai Status Race - American Indian 1 Yas 2 2 III Yas, Giva Year or Dalas: 2 2 No 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: à 3 ☐ Widowed 4 ☐ Divorced "netural". Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) pemit. Pages 1 end 2 should be liled within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, tra Manan Injury or other traumatic event, tra Manan Injury or other traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) LERK GEL 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3/aKeney(sause) elaware are 20a. Malhod of Disposition

1 Burial 2 Cramation 3 Removal from State 20b. Place of Disposition (Name of cematary, cramatory or other place) Date 20c. Location - City or Town, State 18/19 4 ☐ Donalion 5 ☐ Othar (Specify) #1401178 21. Signatura of Fundral Service License 22. Nama and Addrass of Facility 23a Part 1. Enter the disease, or complications that a fised the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock or heart failure. List only one cause opposit in the Approximata Intervel Between Onset and Death **Physician** /Medical Immediele Cause (Final SHOCK diseasa or condition rasulting in death) Examiner Examiner Sequentielly list conditions, if any, leeding to immadiala causa. Enter Underlying Cause (Diseasa or Injury that initialed evants resulting in daalh) Last Dua to (or as a consequence of): and IWEEK SEDINA P.O. Box 68760, physician Physician/Medical the STEROLAS FOR MY ASTHERNA GRAUN Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown signéd d be del Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 10 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Impalient 2 ER/Outpatient 3 DOA 28a. Dala of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 PNetural 1 Yes 2 No death. 2 Accident Director: 3 Suiclda 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Combined the time of the cause(s) and manner as stated.

Combined the time of th 29a, Cartifier and mannar slaled. 29d. Data signed (Month, Day, Year) 8-17-99 29b. Signature and title of certifiar 29c. License number 30. Name Ind address of person who con peath (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** John Duane Brasted 14, 1955 4c. County of Deeth /Medical Aug. 7:30 A.M. 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel Hilloder 1 Ves 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** Hours 1₩ M 2□ F Months Davs 707-01-6950 Director May 29,1927 New York Usual Residenca of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow Director Md. Anne Arundel Crofton 1 Nes 2 No 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 1495 Crofton Parkway 21114 USA Nerna 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Bleck, Whita, atc. Hed within 72 hours after thygiene. Hygiene. ther then "natural", or ite 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be liled wit. Department of Health and Mental Hygiene important: if item 27 ie marked other tha any finlury or other traumatic event. the Lead. 12 Self employed Dry cleaning 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles P. Brasted Marion Giveans 19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gladys M. Brasted 1495 Crofton Parkway, Crofton, Md. 21114 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 08-17-99 Lakemont Mem. Gardens Davidsonville, Md. 21. Signature of Junerel Servica Licenson 22. Neme and Address of Fecility Beall Funeral Home Sharing www. Beall M00798 6512 N.W. Crain Hwy., Bowie, Md. 20715 23e, Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseasa or condition resulting in deeth) Examiner with delsilitation Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1Xoue 1 Yss 2 No 3 □ Probably 4 □ Unknown Division of Vital Records. à 24b. Were autopsy findings available prior fo completion of cause of death? 24a. Wes an autopsy performed? Completed page 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 1 Yes 2 No Other: Warsing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deat 28d. Describe how injury occurred After Hospital or Attending | 24 hours after death. 1 Neturel 5 Pending investigation after death.

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d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could nof be 28e. Plece of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours all To the Funeral D completely filled in 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier

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29b. Signatura and title of cartified

30. Name and address of person who comp





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ed cause of death (Item 23a) (Type, Print)

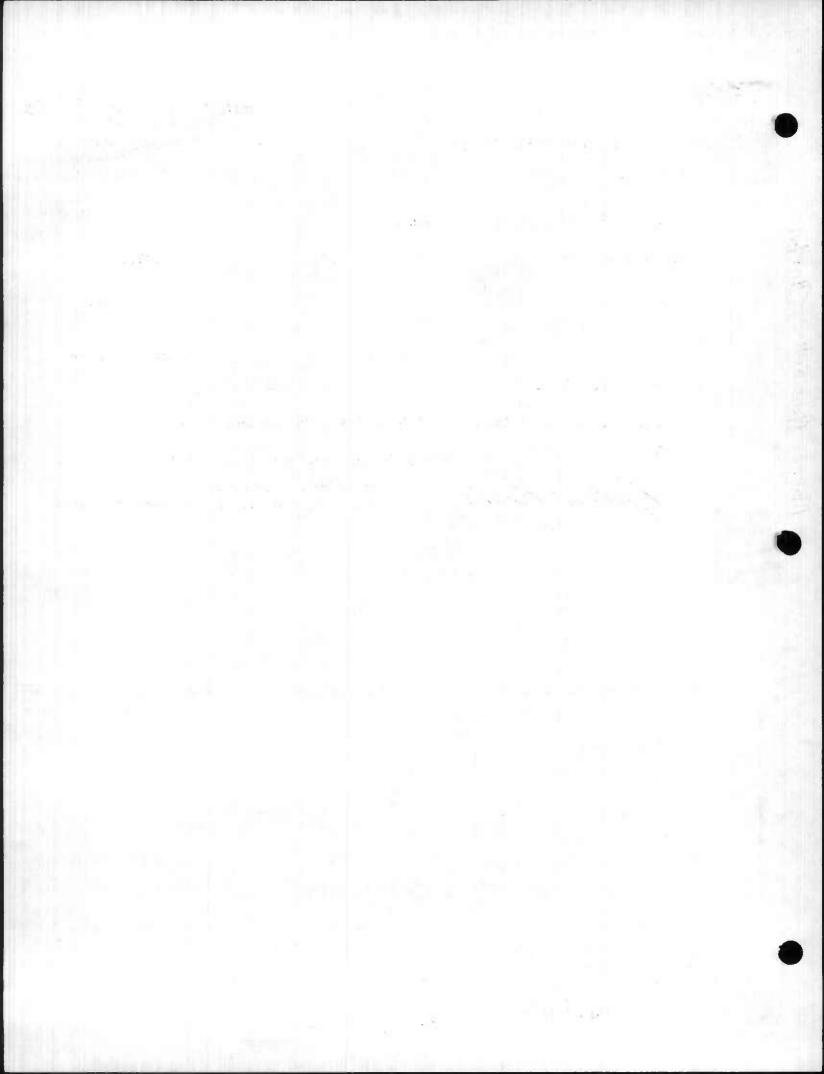
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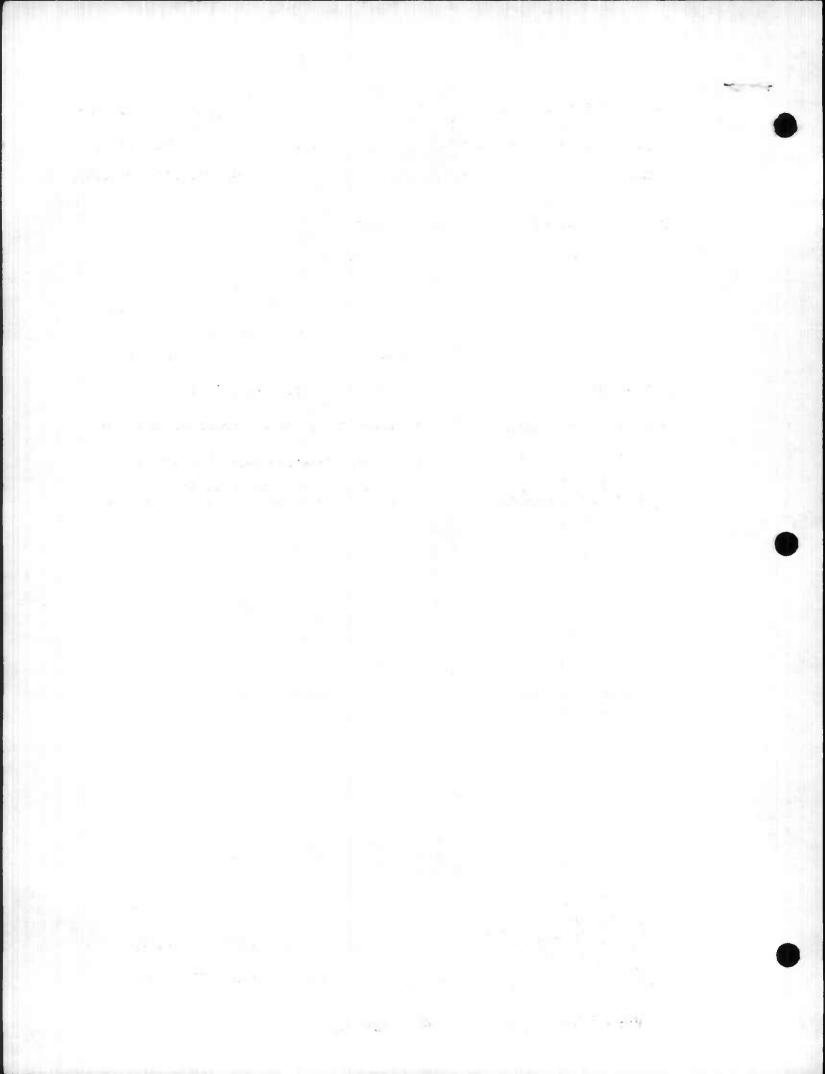
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State of Maryland / Department of Health and Mental Hygiene

							Certificate of	Death		Reg. No.	2 6	7 4 4 0	
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Adelaide -	ah ou	-	19a. Informant's Neme/Relationship (7	Type, Print)		19b	. Mailing Address (Stree	t and Number or Ru			, Stete, Zip Co	de)	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Daeth **Physician** August 13, 1999 Mary Elizabeth Crunkleton 9:30 A.M. /Medical 4e. Fecility Neme (If not institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Hagerstown Washington 7 East Washington St. H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. S. Date of Birth S. Day 0, 7897 5. Sociel Security Number 9. Birthpleca (State or Foreign Pennsylvania 7. Age (In yrs. last birthdey) **Funeral** 1 M 2 VF 220-18-0060 101 Yrs. Director Usual Residence of Decedent with the Maryland show 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Washington Hagerstown 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 7 East Washington St. Apt. 905 21740 items 23a 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-ilf Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, atc. 11. Maritel Stetus Pages 1 and 2 should be filed within 72 hours after near of Health end Mental Hygiene.
ant: if item 27 is marked other then "natural", or iten any or other traumatic event, the Medical Evanines ury or other traumatic event, the Medical Evanines ury or other traumatic event, the Medical Evanines. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: þ Specify: 3 ☐ Widowad 4 ₺ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest greda completed) Elementery/Secondary (0-12) College (1-4or 5+) Key Maker Pipe Organ Co. 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Harry S. Crunkleton Rebecca Jane Pensinger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Ann Cook (Niece) 8546 Country Home Lane Boonsboro, Md. 21713 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stata 1 M Burlat 2 ☐ Cremetion 3 ☐ Reprovel from State Depertment of Important: If any injury or once. Aug. 17,1999 Hagerstown. Md. Donason 5 Other (Specify) Rest Haven Cemetery 21. Signature of Funerel Service Licen 22. Name end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiretory arrast, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Deeth **Physician** /Medical immediate Cause (Final horry diseesa or condition rasulting in deeth) Examine Due to (or es a consequenca of) Physician/Medical Examiner buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. physician s the burie Dua to (or as e consequanca of): been signed by the attendin should be deteched for use Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 25 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evallabla prior to completion of causa of death? 24e. Wes en eutopsy performed? has page 2 20 No certificate 1 Yas 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitet: 1 inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Menner of Deeth 28e. Dete of Injury (Month, Day) 28b. Tima of 28d. Describe how Injury occurred 5 Pending investigation Neturel MA 24 hours efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Contifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. within 2 ş 29c. Licansa number 29b. Signetal and title of certifle 0 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 366 Mill St. Hagerstown W

Begistrer's Signeture

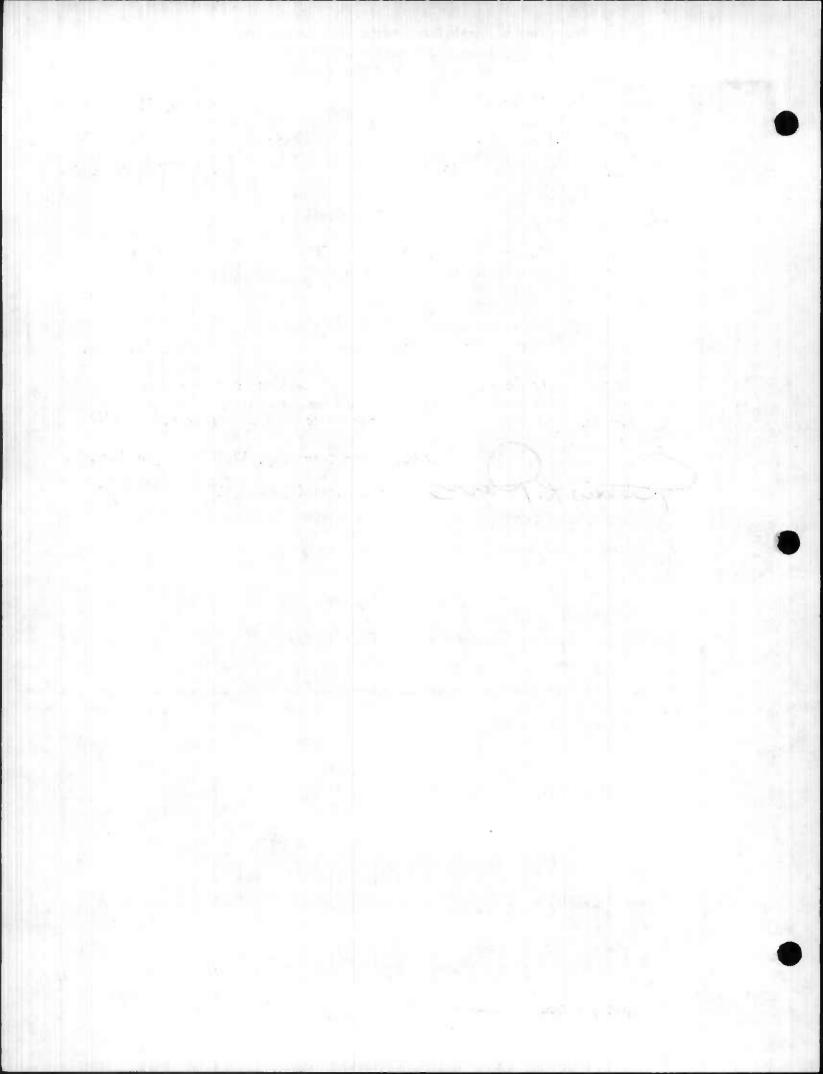
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State

Registrar

31. Dete filed (Month, Dey, Year)

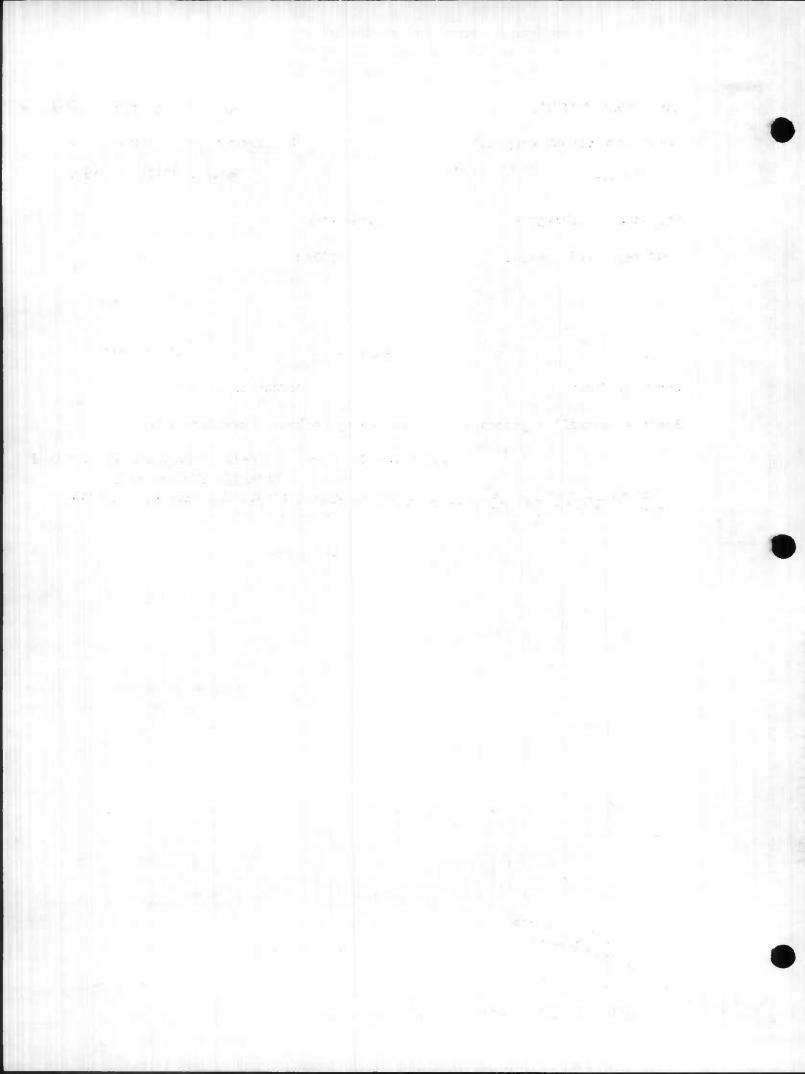
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State of Maryland / Department of Health and Mental Hygiene 99 2715

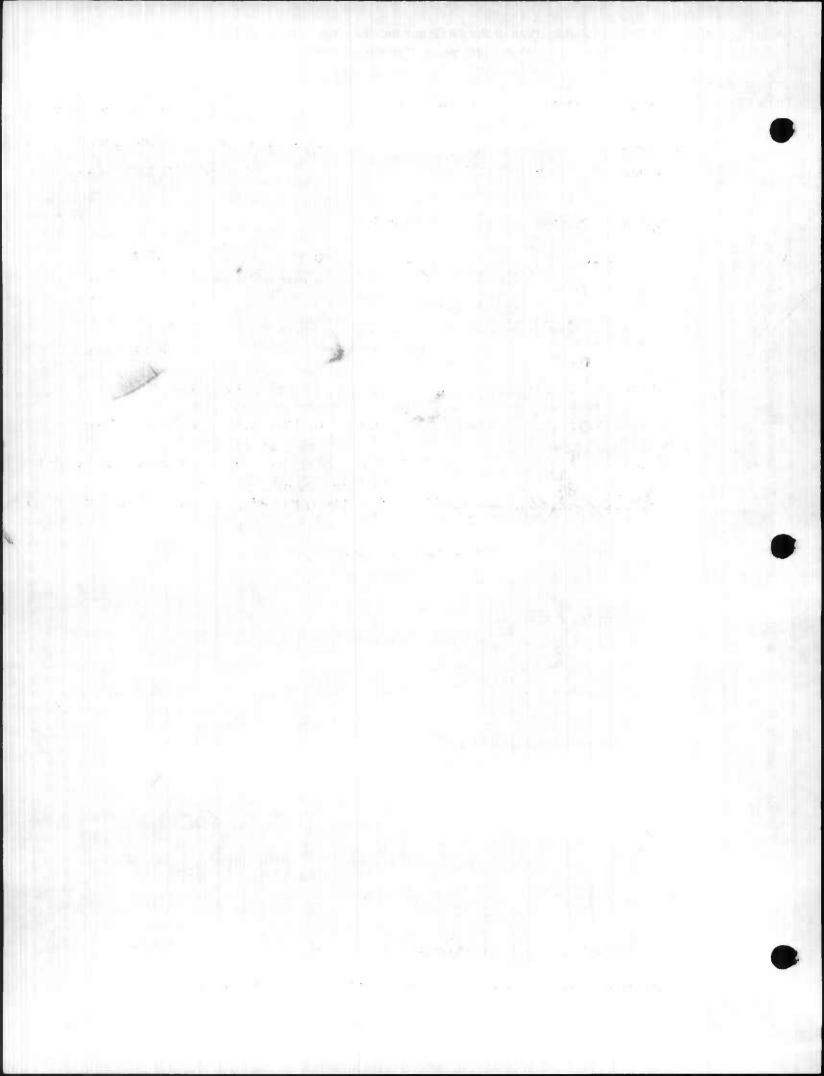
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F		5. Social Security Number 6. S		ge (In yrs. le	st birthd	ev) If Unde	r 1 Yea	If Under 24	erstor Hrs. 8. D	ate of Birth Month, Dey,			eleca (State or Fore etry)			
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and **		10a. Stete 10b. County		10c. City,	Town o	Location						1	0d. inside City Lim			
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21215-0020 d within 72 hours after deeth with the Manyland opene. Spiene. Than "naturel", or items 23s or 28s-f ahow the Medical Examiner must be notified at	by Funeral	11. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Detes:	?				Hispenic Origin ban, Mexican, P Specify:	Puerto Ricar	Yes or No-		ck, White,	etc.			
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Baltimore, pemit. Peges 1 e Depertment of Hea Important: If item: any injury or othe	2000	21. Signeture of Funerel Service Licar				21740										
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Physician /Medica Examine	l r	Immediate Cause (Final disease or condition resulting in death) e. Metastatic Colon Cancer Due to (or es e consequence of):										1				
. BOX 68760, death certificate be executed e ettending physician and of for use as the bunel-transit	ai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	c		e to (or es e consequenca of):											
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Or Attent or Attent of Attention of Attention of Original of the In by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	Yes 2 No	281. Location (Straet end Number or Rurel Route Number, City or Town, Stele)												
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		30. Name and different of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Neal Patalinghus 1110 medical Campus Rd. Haa Md.														
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S	tate	31. Dete filed (Month, Day, Year)		trer's Signete	Ly Ly	10	a. w	,	4			•				

Mary Helen Cottill



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					,	Cen	tificate	e of	Death			Reg. No.			
	Dhi-i		1. Decedent's Name (First, Middle, Last)		,						2. Dete of Dea Month	ath Dey	Yeer	3. Tima of Dea	th
я	Physici /Medic		Melvin Auker	Cu	rley						Aug	19	1999	6:00	AM
	Examir		4s Fecility Neme (If not institution, give :	street end number)							cation of Deeth		131-		
			13 Sandra Court				Killadas		India	n H	ead		arles		
	Funeral Director		552-34-9717	M 2□F 76	e (In yrs. lest bi	Yrs.	ff Under Months		If Under 2 Hours	Min.	B. Dete of Birt (Month, Per September	y. Year) er 8,19	9. Birthp Coun 22 Per	lece <i>(State or Fo</i> try) nnsylvan	ia
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loc	ation						1	0d. Inside City Li	mits
	e Men	ctor	Maryland Charles		Ind	dian	Head	L						1⊠Yes 2□	No
	or 28	Oire	10e. Street and Number				10f. Zip	Code				10g. Citizen of		try?	
	23a	<u>e</u>	13 Sandra Ct.					0640				U.S.			
120	permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow any Injury or other traumatic event, the Moulinal Examines must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yas, Give Year or Detes:	lo		/as Deced Yes, spec □ Yes 2		lispanic Orig an, Mexicen, Specify:	in? (Spe Puerto l	cify Yes or No- Rican, etc.)	Specil	ce - Americ ock, White, by: Whi	etc.	
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nd	d oth	Be	17. Fether's Name (First, Middle, Last)									Meiden Sumer	ne)		
2	should be nd Mental marked o	2	19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No.							Birdie May Auker					
Maryland	end 2 st ealth end n 27 la n														
	Health Health orn 27		20a. Mathod of Disposition	1 50	20b. Ptece	of Dispos	ition (Nan	na of	EL DI.	, 111	Data Data	20c. Location			
Baltimore,	Pages nent of I ant: If Its ury or o	Clifton Curley III Son 4520 Doncaster Dr. 20a. Mathod of Disposition 1 Burial 2 Al Cremation 3 Removal from State 4 Donation 5 Other (Specify) Contact Dr. 20b. Place of Disposition (Nama of cemetary, crametory or other piece) Augumentary (Nama of cemetary, crametory or other piece) Augumentary (Nama of cemetary, crametory or other piece) Augumentary (Nama of cemetary, crametory or other piece) Augumentary (Nama of cemetary, crametory or other piece) Augumentary (Nama of cemetary, crametory or other piece) Augumentary (Nama of cemetary) (Nama of cemeta										Alevano	dria	Virgini	2
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0	the ed	/sic	Part it. Other significant conditions con	tributing to death bu	ut not rasulting	in tha un	derlying c	euse giv	/an in Part I.		23b. Dld	tobacco use co	ontribute to	the cause of de	ath?
<u>a</u>	The law requires that the deeth cerste hes been signed by the ettendir	Ph									10	Yes 2□ No	3 Prol	pably OSUnk	nown
Records,	sign d be	d by									24a Was	en autopsy	24b. W	ere autopsy findi	ngs
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0	Attending Physician: or death. ector: After this certific by the funeral director,	n: T	27. Manner of Death	28e. Dete of Injur (Month, De)	y 28b.	Time of Injury		Bc. Inju		-		how injury occu			
<u>S</u>	ending sath. or: Af	atic	1 Platurel 5 Pending 2 Assident invastigation				М		Yes 2□N	40					
Division of Vital	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be datarmined	28e. Plece of Inju- building, ato		arm, stre	et, factory	, office		1	281. Location (: City or To		ber or Rura	il Route Number,	
	pital o	S	200 Coddies 45 double to Dhu	John To the heat of	d and the souls do			-4 44 - 45		d place of				lata d	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Cartifiar (Check only one)	nar: On the basis of end manner sta	axamination e	nd/or inv	estigation,	, in my	pinion, daat	h occurr	ed at tha tima,	data end place	, and due to	the cause(s)	
	o the	Me	29b. Signature and title of certifier				290	c. Licens	se number			29d. Date sign	ed (Month,	Dey, Year)	
	C>F0		* Herris	M. ME	-On	-			D2835	52		Augu	st l	9, 199)
			30. Nama and addrass of person who co	mpleted cause of de	eath (Itam 23a)	(Type, F	Print)								
			Krishan Mathu		P.O.			3,	La E	Plat	a, MD	20646			
	Sta	te	31. Date filed (Mogth, Day, Year) AUG 2 3 199	32. Registra	r's Signature	1		,							
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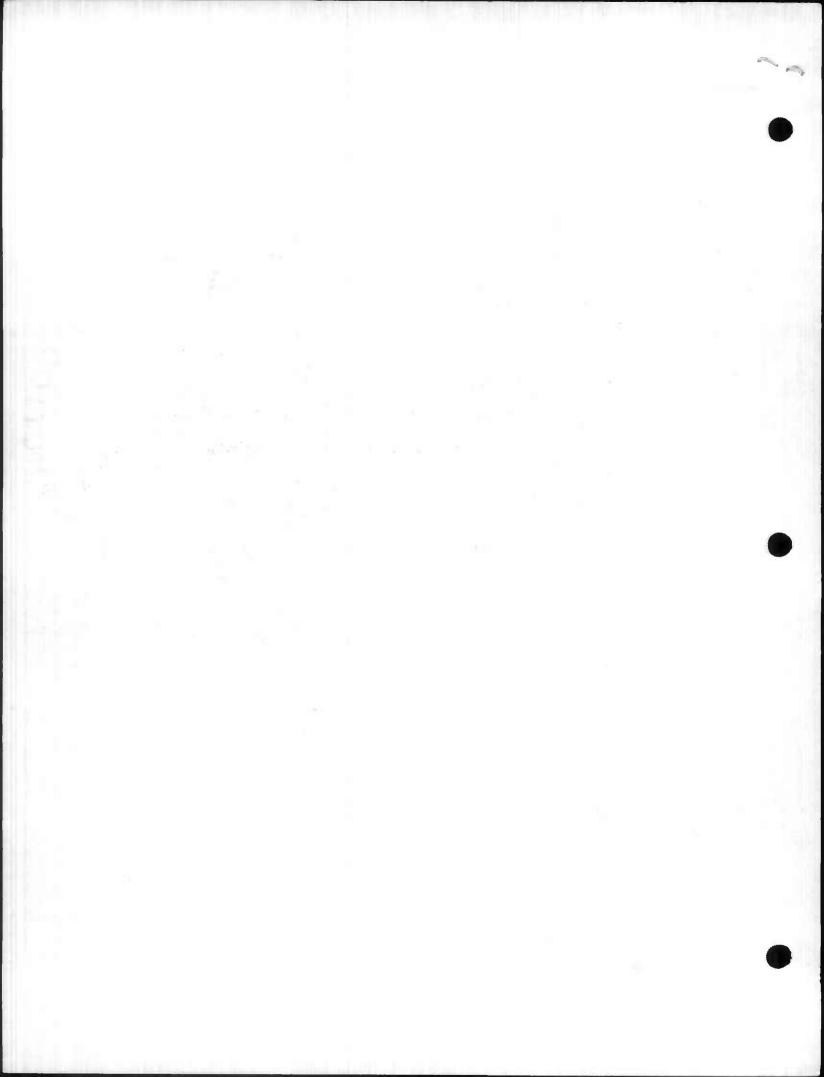
STATE REGISTRAR OMIT ER MARKING

DIVISION OF VITAL RECORDS, P.O. BOX 68766 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w

1 DECEDENT'S NAME (First Middle | ast) 2. DATE OF DEATH 3. TIME OF DEATH 1999 YEAR DAY William Alden CRUMBACKER August 14, 7:33 p. 4. SOCIAL SECURITY NUMBER 8. AGE (In vrs. lest birthdev) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 214-09-9498 1 1 N M 2 □ F Oct. 21, 79 1919 Pennsylvania Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 1038 Spruce Street Hagerstown Washington DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Hagerstown w.county Washington Maryland 10d. INSIDE CITY LIMITS? 1 X YES 2 □ NO permit. 10g. CITIZEN OF WNAT COUNTRY? FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 1038 Spruce Street 21740 U.S.A. funeral director, page 5 should be detached for use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuben, Maxican, Puerto Ricen, etc.) 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 1 YES 25 KNO Specify: Specify: white BY 3 🔀 Widowed 4 🔲 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 0 - 8store manager grocery store 17. FATNER'S NAME (First, Middle, Last) ts. MOTNER'S NAME (First, Middle, Meiden Surname) William Crumbacker Erma unknown 70 notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Judith A. Miller/daughter 11025 Clinton Avenue, Hagerstown, Maryland 21740 pe 20e. METHOD OF DISPOSITION
1 🖾 Burlel 2 🗆 Cremetton 3 🗀 Removal trom State
4 🗆 Donation 5 🗀 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Aug. 18.1999 Rest Haven Cemetery Hagerstown, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland L. Vestel Ined filled in by the medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one ceuse on each line. Interval Between 0 **Onset and Death** IMMEDIATE CAUSE (Final the cremation, disease or condition completely acue resulting in death) other traumatic event, burial, CERTIFICATION and Sequentially list conditions, prior to if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury Hygiene p OUE TO (OR AS A CONSEQUENCE OF that initiated events the attending p resulting in deeth) LAST Vea 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WALKIN AUTOPST PERFORMED? 24b. WERE AUTOPSY FINDINGS this certificate has been signed by with the State Dept. of Health and AMAILABLE PRIOR TO ralmer any COMPLETION OF CAUSE 1 TES 2 NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 26. PLACE OF OEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL EXAMINER? tem HOSPITAL OTHER t YES 2 WHO I | Inputient 2 | Envoytpatient 3 | DOA 4 Nursing Nome 5 Residence or in 27. MANNER OF GEATN 200. OATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCUREO 28c. INJURY AT WORK? marked, 1 7 Natural 5 Pending t YES 2 NO ВУ DIRECTOR: After the hours after death vitem 28 is mart Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 3 Suicide ETED. 4 Nomicide datermined 29e. CERTIFIER 1 CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 THE IMPORTANT: If It MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF MD 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF BEATH (ITEM 27) (Type, Print, gar 0 ile 31. DATE FILED (Month, Day, Year)
AUG 1 8 1999 32. REGISTPAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Tima of Death Camper oah James August 11 1999 1638 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death The Memorial Hospital Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 100 M 2□ F Months Days 220-01-026 Usual Residence of Decedent 5 Yrs. 1914 Maryland APR:/25. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Was 2 No albot Rap 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 65 TRappe Roa 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 2167 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 1□ Yes 202No specify: Black Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Carpenter ENTREPRENEUR 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ve Danie Camper aRROLL Katie 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) TRappe Road TRappe, Mary land 2/673 e of Dete 20c. yoution - City or Town, State Mary 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/18/99 Paradise Cemetery 4 ☐ Donation 5 ☐ Other (Specify) TRappe Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home Henry Funeral 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Maryland 21613 Approximate Intervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of) puagoa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown to brill ation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

or 28a-f

Camper

Jame

Noah

21215-0020

Saltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

Health I

Physician/Medical Examiner physician s the burie þ Completed page 2 s Be Certification: To this After 24 hours after death. Funeral Director: A

The law requires that the death cartificate be asscuted

Box 68760.

P.O.

of Vital Records.

Division

or Attending

Hospital

Within 2

25. Was casa referred to medical examiner? 1 ☐ Yes 2 🗙 No 27. Menner of Death 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel

29c. License number

00053110

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis M. DeShields, M.D. 219 South Washington Street, Easton, MD 21601

State Registrar

filled in by

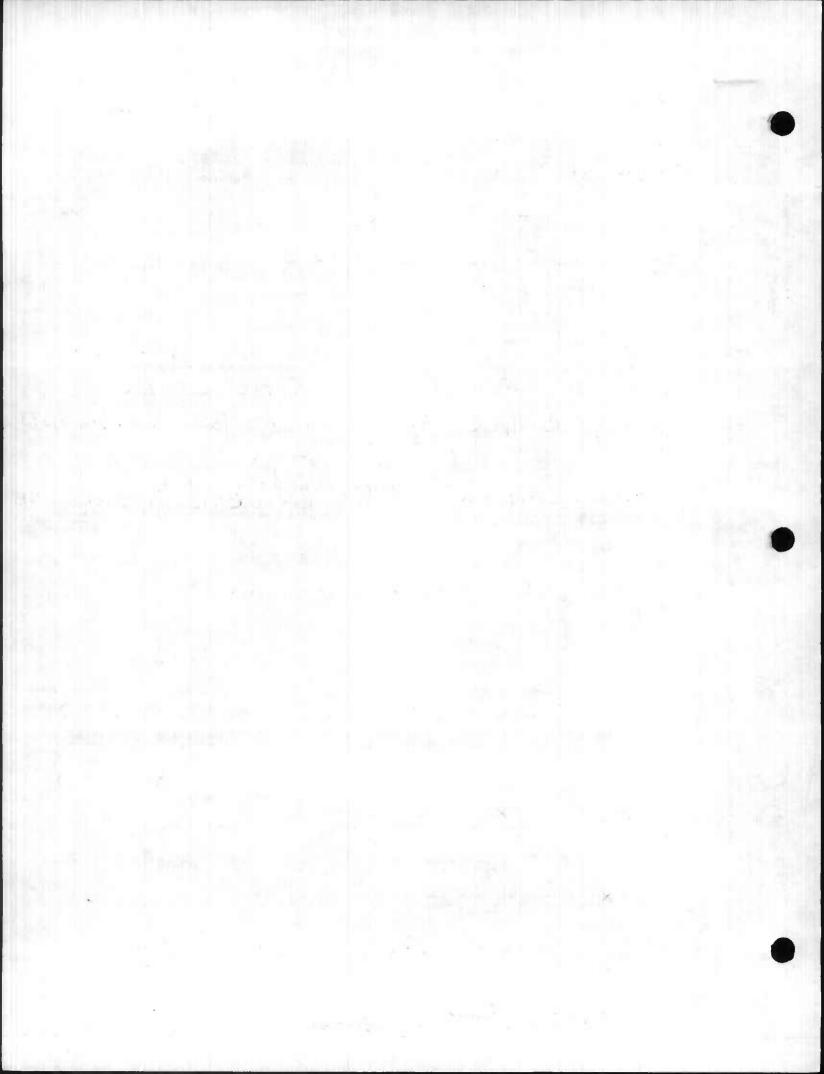
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29b. Signature and title of certifier

31. Date fited (Month, Day, Year) AUG 1 6 1999

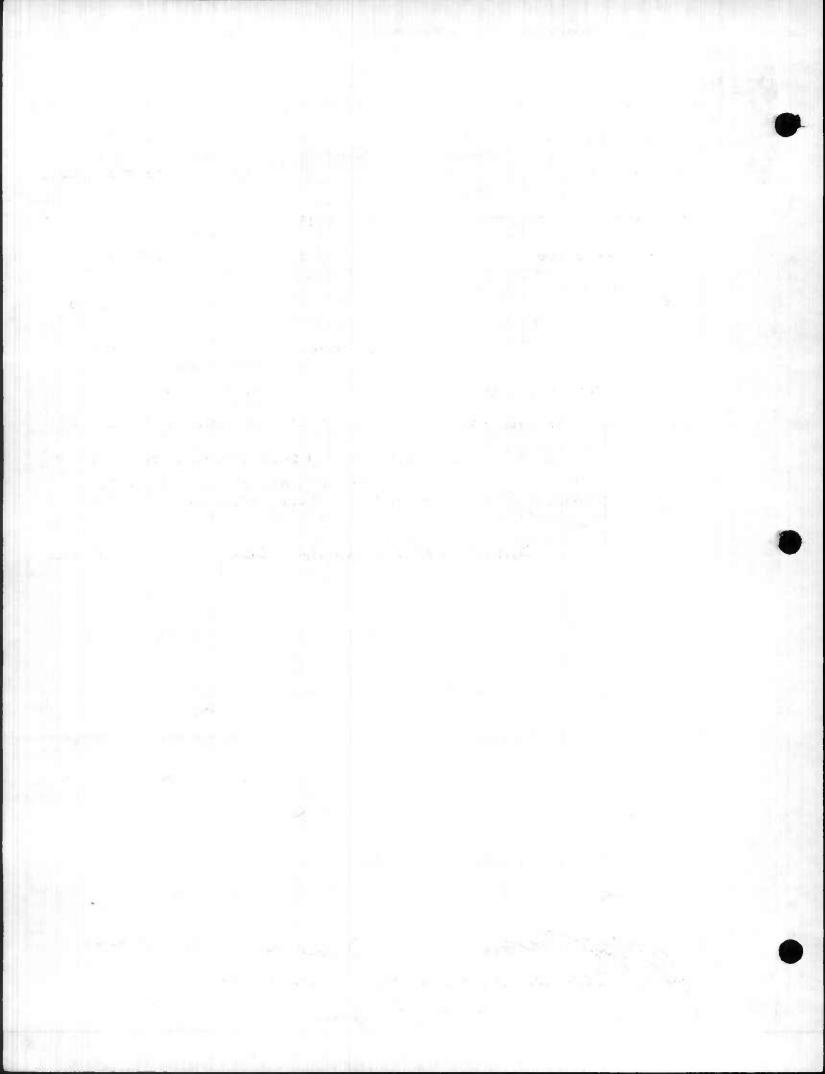
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Aug. 15, Day 999 Thyra Rae Carkuff 12 Noon /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Cambridge Chesapeake Woods Center Dorchester 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 5 Social Security Number 6. Sax Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1□ M 2XF Deys Yrs. Director 266-19-8655 80 Mar. 4, 1919 Illinois Usuel Residence of Deceden 10a State 10h Counts 10c. City, Town or Location 10d. inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? or thems 23a or 14 Harris Drive 21613 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11. Maritei Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bieck, White, etc. the Medical Examiner 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à Specify 72 hours 3X Widowed 4 ☐ Divorced "natural". White Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Department of Health and Mental Hy Important: If flem 27 is marked othe any injury or other traumets. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Unknown First/ Reckard Florence Bowers 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John Michael Carkuff/Son 14 Harris Dr., Cambridge, MD 21613 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremetion 3 🖫 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Southern Memorial Park 8-21-99 North Miami, FL 22. Name and Address of Facility Curran—Bromwell Funeral Home, P.A. 21. Signatura of Funeral Service Licensee nuvell 308 High St., Cambridge, MD 21613 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, or heert feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence ot): physician a s the burial-Box 68760 Physician/Medical the Due to (or es e consequence of): 8 attending | P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 18 Yes 2 No 3 Probably 4 Unknown signed b Records, þ ate has been signated bage 2 should b 24b. Were autopsy tindings aveilebie prior to Completed 24e. Wes en eutopsy completion of cause of death? 1 Yes 2 1 No 1 ☐ Yes > No certificate of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica tiety filled in by the funeral director, p. 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred Division 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a, Certifier 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name and adul s of person who completed cause of deeth (Item 23e) (Type, Print) Fooder No Huslack 302 colling Melnel 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State Registrar AUG

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9

					Ce	niiica	te oi	Deat	n		Reg. No.			
Physician /Medical	KEITH	ome (First, Middle, Li DANA De	OWNEY							2. Date of De Month 08	15	Year 99	3. Time of Death 11:10 pm	
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or 28s-fah be notified Director	Maryland		George	's I	'emple					1			1 ∑ Yes 2 No	
Oir Dir	10e. Street end f					10f. Z	p Code				10g. Citizen of		ntry?	
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ygiene, wer than "natural", or itame 23a or 28a-f show it, the Medical Exeminant be mouthed an Completed by Funeral Director	11. Marital Status 1 Never Ma	s arried 2☐ Merried d 4涨 Divorced	Armed F	2 No ive	0,5.	If Yes, sp				pecify Yes or No Rican, etc.)	Speci.	ick, White,		
		15. Decedent's E	ducation		16e. Dec	edent's Us	uel Occ	upetion			16b. Kind of E			
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Be C	17. Father's Nem	ne (First, Middle, Las						18. Mo	ther's Nam	ne (First, Middle	, Meiden Sume	eiden Sumeme)		
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rtra	Edna Do	owney/Sist	ter		104	Shutt	er	Stree	t, Ch	narlest	own, W.	Virginia 25414		
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any ir	l b a l	A 100												
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page 2 should			V							≥48. We	s en eutopsy ormed?	90	Vere eutopsy findings veileble prior to ompletion of cause	
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//		idress of person who	completed cau	use of deeth (It	em 23a) (Type	Print)								
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State	e 31. Dete filed (Month, Dey, Year) 2. Registrar's Signeture													
Registrar	AU	G 2 0 1999	100g	1	1	Show	-				-			
			-											

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Kathleen Olivia DeLOUNEY 13, 1999 8:25 p.m. August 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Williamsport Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) Sept. 10,1912 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys 1 □ M 2 🖾 F 86 Yrs. Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Hagerstown DOYes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 433 Ridge Avenue 21740 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detea: 14. Rece - American Indien, Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried white 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Ò electrical worker aircraft co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Shank Minnie Roser 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carrie L. Burkholder/daughter 5 West Irvin Avenue, Hagerstown, Maryland 21742 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from State August Rose Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 17,1999 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death DEHYDRATION 10 DAYS EREBRAL 10 DAYS WITH FNFARCT Due to (or as a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS 24b. Were autopsy findings sysilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760,

Examiner Attanding Physician: The lew requires that the death certificate be executed use as the burial-transit P attending physician for use as the buria ate has been signed by page 2 should be detac this certificate director, Inneral After death. spital or Atlandi nours after death. heral Director: A filled in by the I To the Hospital o within 24 hours af To the Funeral DI completely filled in

Physician

/Medical

Physician

/Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a4 ahremany injury or other traumatic avant

Baitimore, Maryland 21215-0020

5. Sociel Security Number

214-09-5594

10e. State

Director

Funeral

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Completed

Be

P

Examiner

Maryland

10e. Street and Number

Usuel Residence of Decedent

Elementery/Secondery (0-12)

Scott

0 - 8

20a. Method of Disposition

Immediete Cause (Finel diseese or condition resulting in deeth)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. DIABETES à Completed Be 25. Wes case referred to medical 1 Yes 20 No Medical Certification: To 27. Menner of Deeth 1 Netural 2 ☐ Accident 5 Pending investigation 3 Sulcide 6 Could not be 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) and menner as steted.
2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

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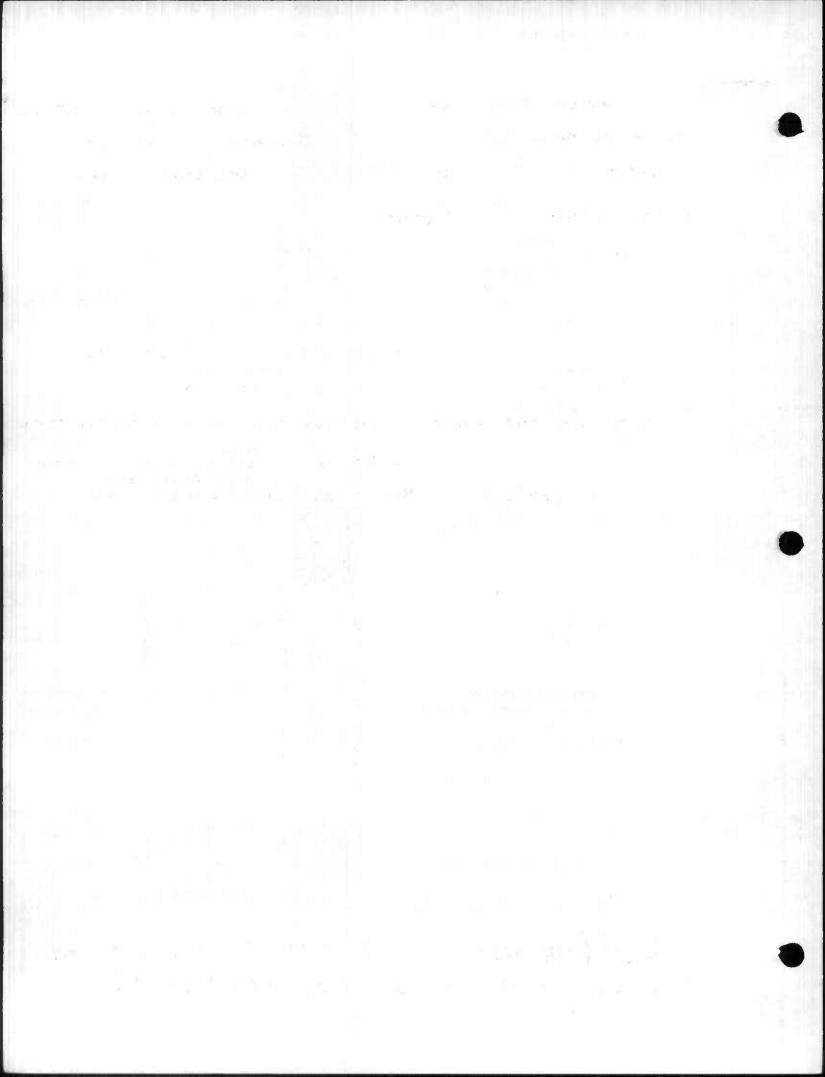
42

OVERLOOK

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

31. Dete filed (Month, Day, Year)
AUG 1 6 1999

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

If Under 1 Year

7. Age (In yrs. lest birthdey)

Certificate of Death 2. Dete of Death 3 Time I Death 23:55 21, 1999 4c. County of Deeth August

Elkton

4b. City, Town, or Location of Deeth

Cecil

Physician
/Medical
Examiner

1. Decedent's Nama (First, Middle, Last)

Alfred K. Diller

Union Hospital

5. Social Security Number

4e. Fecility Neme (If not Institution, give street and number)

6. Sex

Funeral Director

death with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours efter Hygiene. permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I

21215-0020

Baltimore, Maryland

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed burial-transit and Box 68760. physician the USB BS signed by the al P.O. Division of Vital Records. page 2 certificate funeral director, this After

efter death. filled in by the Hospital within 24 hours of To the Funeral C completely \$ 2 DOXIVE

If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys 1 M 2□ F Months Yrs. 171-20-5351 January 1, 1925 Pennsylvania Usuel Residence of Decedent 10e Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 No Pennsylvania Lancaster Intercourse 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? United States Funeral 3732 Country Lane 17534 11. Maritel Stetus 12. Was Decedent Ever In U,S. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. Armed Forces?
Programmed Forces?
Programmed Forces? 1 ☐ Never Married 2 ☐X Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowad 4 ☐ Divorced Year or Detes: Completed 15. Decedant's Education (Specify only highest grede completed) 16a. Decedant's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) Elementery/Secondery (0-12) Collega (1-4or 5+) Electrical Contracting 12 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Martin A. Diller Mary Kling 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 3732 Country Lane, Intercourse, Pennsylvania 17534 Dorothy L. Diller/ Wife 20b. Placa of Disposition (Name of commetery, crematory or other piece)
Zeltenreich 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State New Holland, 4 ☐ Donation 5 ☐ Other (Specify) 8/26/99 Pennsylvania Cemetery 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Deeth Immedieta Cause (Finel hours diseese or condition rasulting in deeth) Due to (or as e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled avents resulting in death) Lest Dua to (or as a consequence of): Physician/Medical Due to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☑ Unknown noul þ 24b. Wara autopsy findings aveileble prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1⊠Yes 2□ No 2 KER/Outpetient 3 □ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Invastigation 1 Netural 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledga, daath occurred et the tima, date and placa, end due to tha causa(s) end manner as stated.

Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, daath occurred et tha tima, dete end place, end dua to the ceusa(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end titla of certifier 29c. License number 29d. Dete signed (Month, Day, Year) TJONGSON 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) Hospita Emergency Inion

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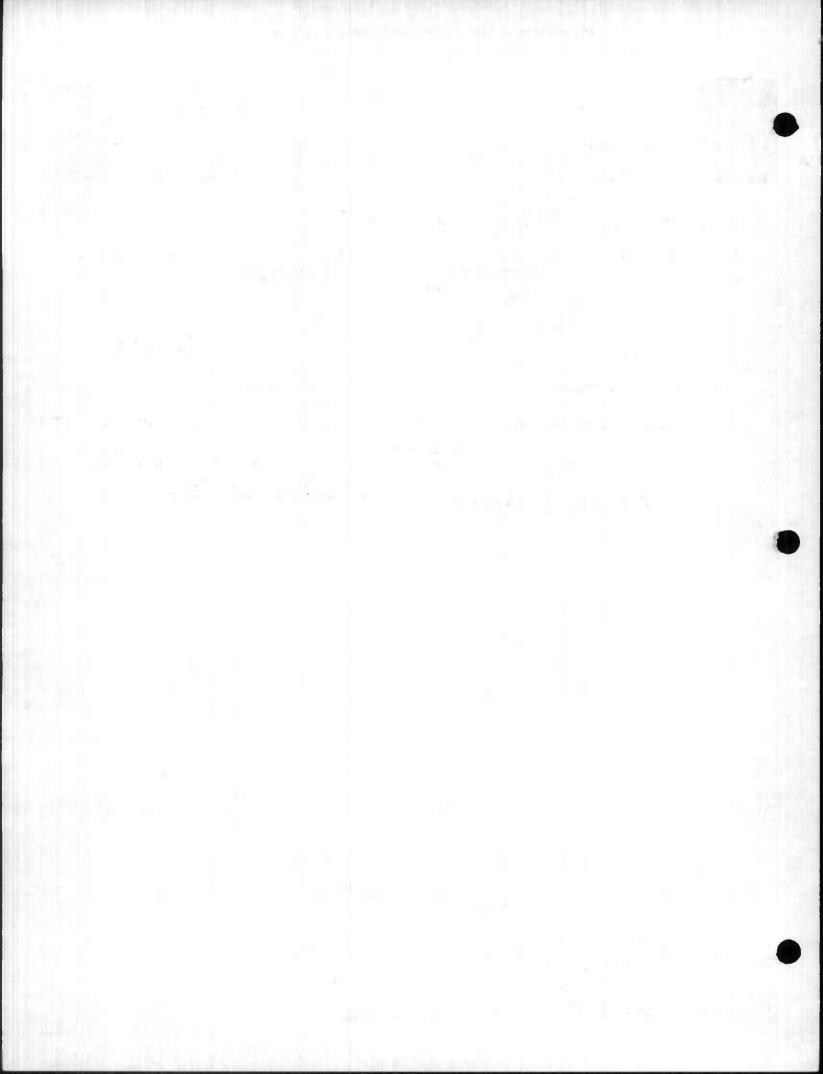
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Registrar

31. Data tiled (Month, Day, Year)

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32. Registrar's Signetute



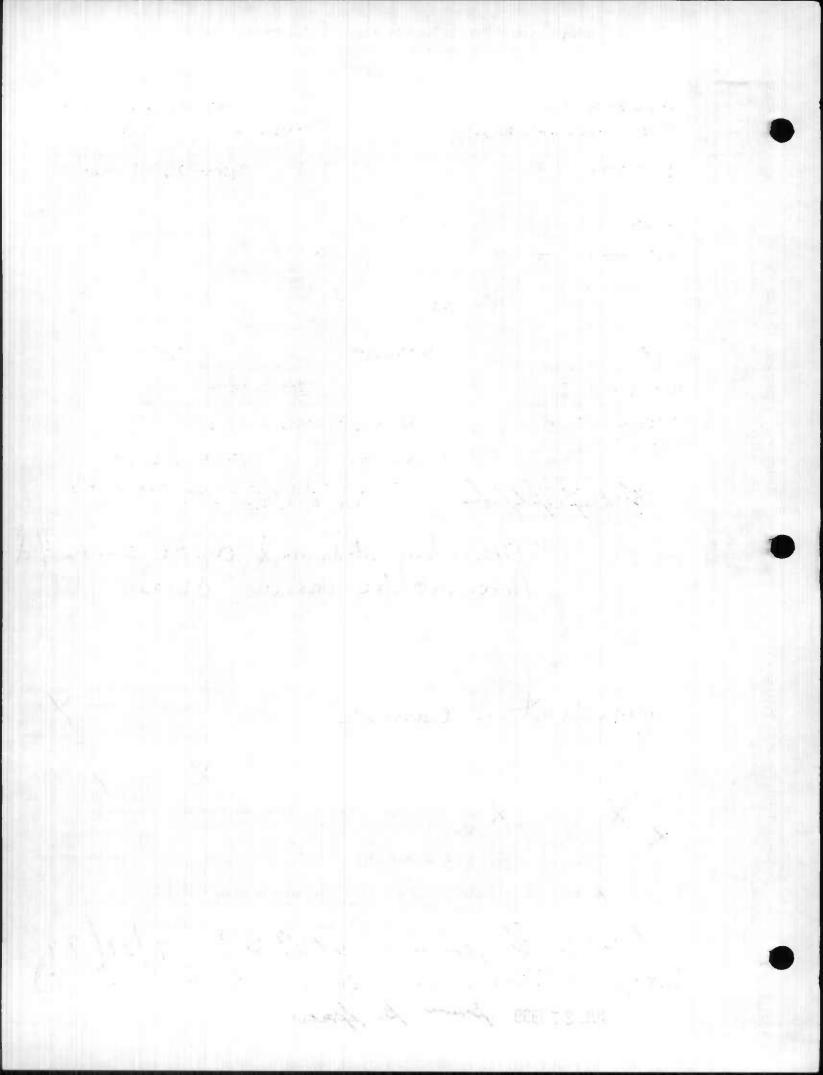
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'a Name (First, Middle, Last) 2. Dele of Death 3. Tima of Death Day **Physician** July 26, 1999 Lewis Hyson Dill 0730 /Medical 4b. City, Town, or Location of Deeth Chestertown 4a Facility Name (If not institution, give street and number)
Kent & Queen Anne's Hospital 4c. County of Death Kent **Examiner** | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. Year) | 9. Birthplace (State or Country) | Septimeber 11, 1917 | Worton, MD If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 □ F 81 216-05-7670 **Director** Usual Residence of Decedent with the Marylend 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f shot treumstic event, the Modical Exameter must be notified at 1 Yes 2 No Directo Maryland Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24479 Porters Grove Road 21678 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours after or Department of Heelth and Mental Hyglene. Important: If Item 27 Is marked other than "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Aq Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwright Agriculture 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Hope Hyson Dill Ida L. Mason 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 Skipper Court, Chester, MD 21619 Keith H. Dill/Son other 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Weuriei 2 ☐ Cremation 3 ☐ Removal from State Injury or 4 □ Donation 5 □ Other (Specify) 5/29/99 St. James Cemetery Worton, MD 21 Signature of Funeral Service Licenses 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onsel end Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner 1030/8 certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Ceuse (Disease or injury that initiated events resulting in death) Last physician and the burief-tren Due to (or as a consequence of): Physician/Medical Due to (or es e consequenca of): as 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.O. Unknown 1 Yes 2 No 3 Probably Division of Vital Records, by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? certificate hes 2 No funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 3 Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA 1 Yes Inpatient this 28a. Date of Injury (Month, Day Year) 27 Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 24 hours Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Wedical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature end little of cartifier Name and address of person who completed cause of death (Item 23a) (Type, Print) ay ne 2

State Registrar 31. Date filed (Month, Dey, Year)

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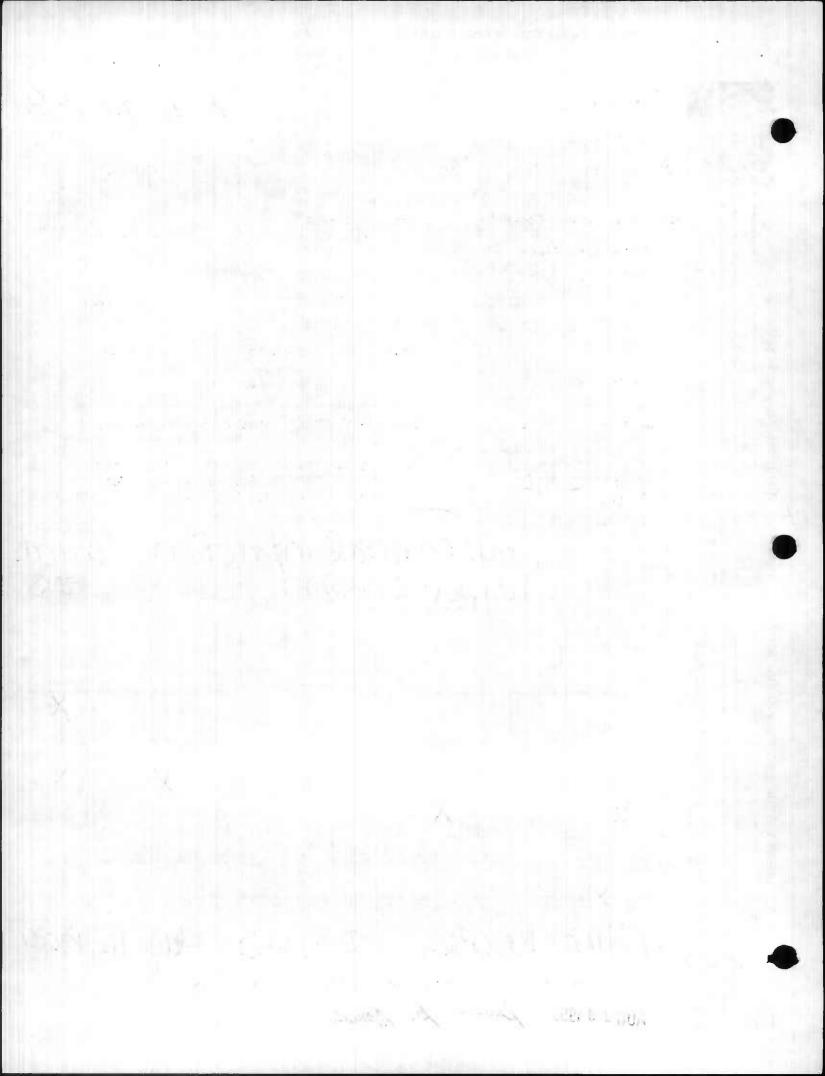
32. Regist

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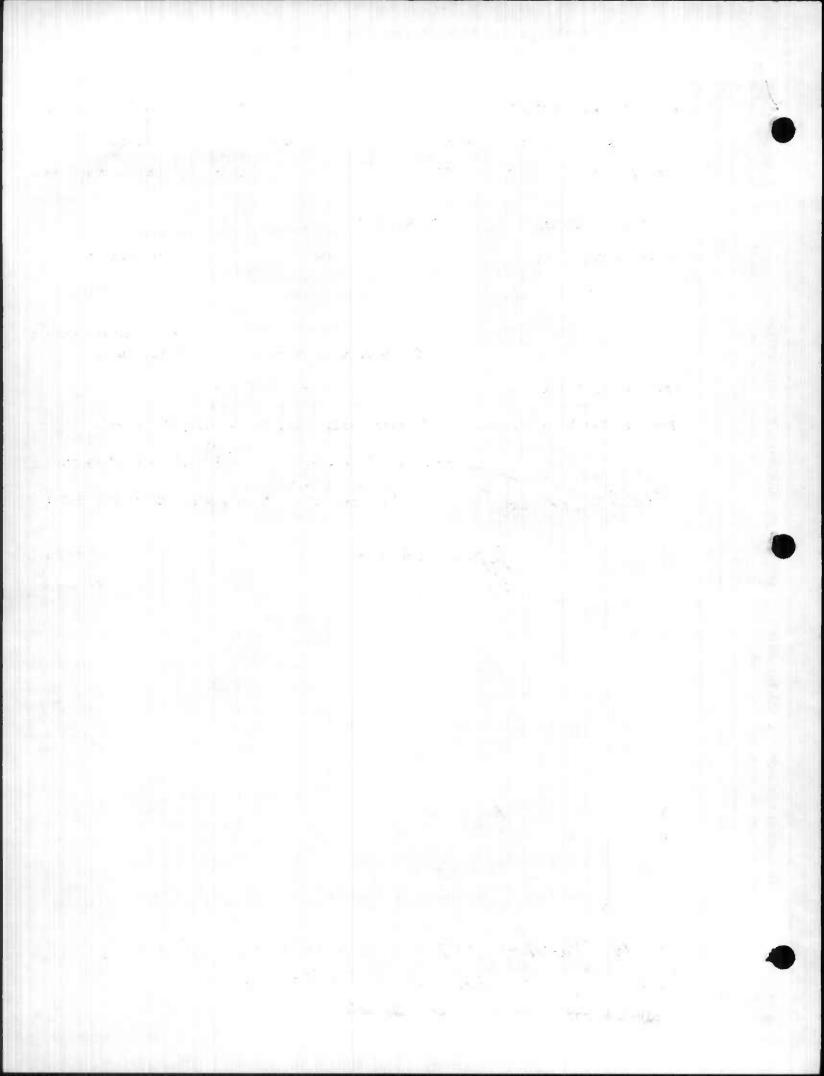
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	Physician	1. Decedant's Nama (First, Middla, Jefferson Din						2. Data of D	eath Day	1999	3. Tima of Death	
	/Medical Examiner	4a Facility Nama (If not institution, Prince George					4b. City, Town, or Chever				eorge's	
	Funeral Director	5. Social Security Number 251–52–1116	3. Sax 1 M 2 □ F	7. Aga (In yrs. 1	ast birthday) Yrs.	If Undar 1 Yaar Months Days	If Undar 24 Hrs Hours Min	8. Date of Bi	orth 9 ^{Year)} 1930	9. Birthpi Coun Sout	laca (Steta or Foreign	
	pue »	Usual Rasidance of Decedent 10a. Stata 10b. County		10c. City	, Town or Lo	cation				11	0d. Insida City Limits	
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	or 28a-f s or 28a-f s be notified	10e. Streat and Number				10f. Zip Coda			10g. Citizen of		•	
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Maryland 21215-0020	12 sho h end lis me treum	19a. Informent's Neme/Relationshi				Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)						
	ges 1 and 2 sh to of Health and if from 27 is m or other froum	Ella Pickett - Wife 500 - 69th Place, Seat Pleasant, MD 20743 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Sta										
OE .	2 # 9 9	14 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.		8/23/99	Chelt	anham	MD					
Baltimore,	permit. Pege Department of Important: if any injury or once.	21. Signature of Puneral Service Li	censee/	4		2. Nama and Addra			Funeral			
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	Physician /Medical Examiner	Immediate Ceuse (Final disass or condition resulting in death)	a.	Due to (o	OUTO	under original pulsars of a spirit	Me Control	w K	arrast,		Approximata Interval Between Onsat and Death	
Box 68760,	thet the death certificate be executed ed by the ettending physician and deteched for use as the bunel-transit Physician/Medical Examiner	Sequantially list conditions, if eny, leading to immediate causa. Entar Undarlying Causa (Disaasa or injury that initiated avents rasulting In death) Last	b	1	r es e consec r as a conseq						ya V	
O. B	net the death certi d by the ettending seteched for use e Physician/M	Part II. Other significant condition	s contributing to d	eath but not rase	ulting in the u	ndarlying causa giv	van in Part I.	23b. Did	d tobacco usa co	ontribute to	the cause of death?	
Δ.	thet the ned by detection of the detection of the head by Phy							10	Yes 2 No	3 Prol	bably 40 Unknown	
Vital Records,	The law requires the ate hes been signed; page 2 should be del							per	s an autopsy formed?	co of	ara eutopsy findings ailable prior to mplation of causa death?	
ta	certificate he rector, page	25. Was cesa rafarrad to medical			^		26 Place of D	aath (Check only	Yas No	11	Yas 20 No	
of Vi	2 00	axaminar? 1 □ Yas 2 ☑ No	Hospital: 1 🗆	Inpatiant	ER/Outpatier	nt 3 DOA Oth	ser-	_	sidence 6 🗆 Oti	nar (Specif	у)	
Division o	or Attending after death. Director: Atte In by the fune ertification	27. Mapriar of Death 1 Neturel 5 Panding 2 Accident 3 Suicide 6 Could no 4 Homicide determine	tion 28e. Place	ith, Day Year)	28b. Time o Injury ome, farm, str	Wo	ryat rk? Yas 2 ☐ No	28f. Location	(Street and Num.		ni Route Number,	
	To the Hospital within 24 hours. To the Funeral completely filled Medical Co	29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.										
	within To the complete Med	29b. Signature and Atla of certifier	ullo	Uliz		29c. Licens	sa number	2	Abag	14	Day, Year) 1999	
	(3)	30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print) M. Kanhouwa 3001 Hospital Drive, Cheverly, MD 20784										
	State Registrar	31. Data filed (Month, Dey, Year) AUG 1 9 199		Registrer's Signe	b.	books						

Registrar DHMH 16 Rev 6/95



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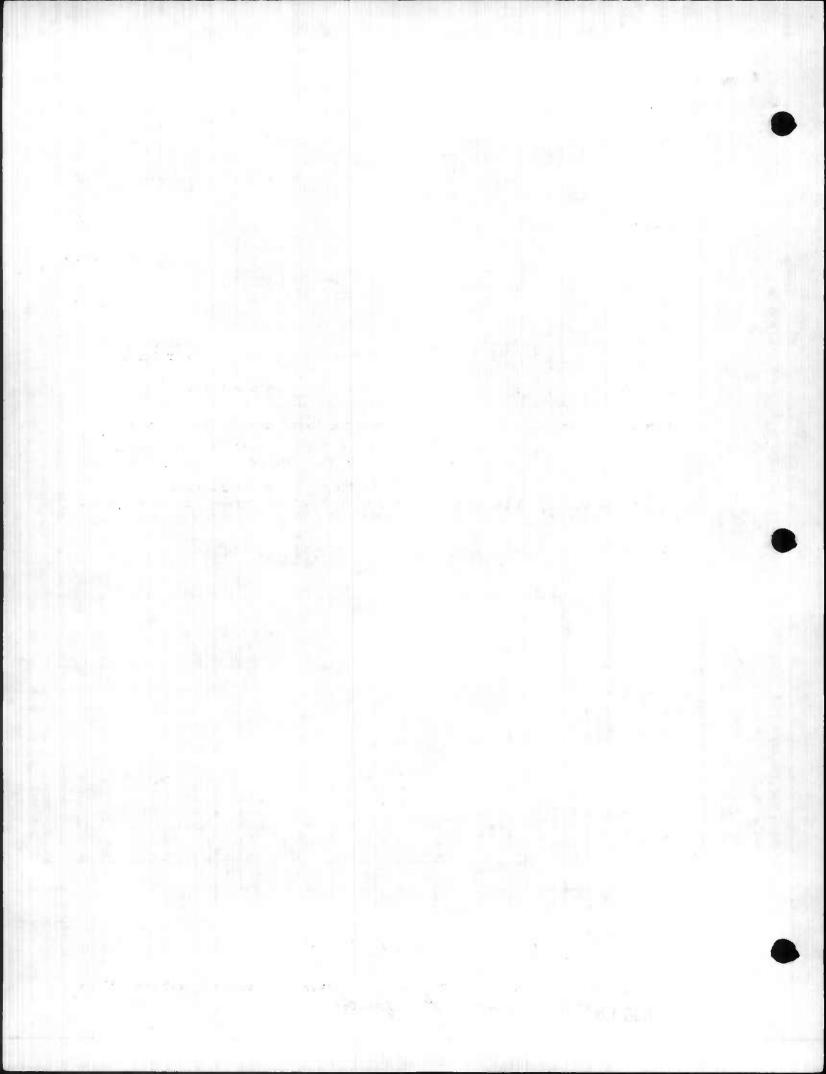
						Certifica	te of	Death	R	eg. No.		170	
1			1. Decedent's Name (First, Middle, Las	st)					2. Date of Deet Month	h Dey	Year	3. Time o	f Death
ľ	Physici /Medic		ELEANOR L. EF	RICKSON					August		99	17:	36
	Examin		4a Facility Name (If not Institution, give					4b. City, Town, or	Location of Death	4c. County	of Death		
A			Union Hospital of	Cecil Count	У			E1ktc	on	Ce	cil		
	Funeral		5. Social Security Number 6. S		s. lest birt	thday) If Und Months	er 1 Yea			Year)	9. Birthp	place (State	or Foreign
П	Director		169-32-9661	□M 2⊠F 5	8	Yrs.			July 18	3, 1941		nnsy1v	
	p 2		Usual Residence of Decedent 10a. State 10b. County	100	Town	n or Location					- 1	IOd, Inside (The Limite
	anyle eho	5	Too. County	100.									2 200 No
	he M	Director	Maryland Cecil 10e. Street and Number		Nor	th East	ip Code		1	0g. Citizen of W	What Cour		
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_	iter d	E I	1 ☐ Never Married 2⊠ Married	Armed Forces? 1 ☐ Yes 2⊠ No	0,0.	If Yes, sp	acity Cul	ben, Mexican, Puer	to Rican, etc.)		k, White,	etc.	
)20	I'. or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 🖾 No	Specify:		Specify	: Wi	nite	
9	n 72 hours efter death with the Marylend "naturel", or items 23s or 28s-f show poics! Exprover must be notified at	8	15. Decedent's Ed		160.	Decedent's Us				16b. Kind of Bu	usiness/in	dustry	
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pu	e filed within at Hygiene. I other than vent, the Ma	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle, I	Maiden Sumam	.e)		
/lai	Aente Aente rked tice	To	Meredith M. Milli	S				Evelyn	Moore				
Maryland 21215-0020	d 2 should be filed within the and Mentel Hygiene. 7 le marked other than treumatic event, the Mentel than the mentel than the mentel than the Mentel than the		19a. Informant's Name/Relationship (7	Type, Print)	19b	. Mailing Addre	ss (Stree	et and Number or R	ural Route Number	City or Town,	State, Zip	Code)	
Σ			Wayne H. Erickson	/ Spouse	71	Kirks	Mill	Lane, No	orth East	, MD 2	1901		
ore	of Heal of Heal fitem 2 r other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □		. Place of cemeter	Disposition (Na), crematory or	ame of other pl	ace)	Aug. 24	20c. Location -	City or To	own, State	
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alt	permit. Peges 1 an Department of Heal Important: If item 2 eny Injury or other once.		21. Signature of Funeral Service Incom	See				ress of Facility	20				
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	/Medical Examiner		Immediate Cause (Finei disease or condition	· Septio	- 5	hock	,					hous	-5
	Examiner		resulting in death)	a. Septice b. Pne am	(or as a	consequence of	f):				1	hous	
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	icate be executed physician end s the buriel-transit	хап	Sequentially list conditions, if any, leading to immediate			consequenca of							
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	<i>i</i> 2		30. Name end eddress of person who	completed ceuse of deeth (I	em 23a)	(Typa, Print)	1 0	11/2	~ 0				
			at Date Glad Many Day	1) Unio	小树	ospital	1	1 /On	1				
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State of Maryland / Department of Health and Mental Hygiene 99 27462

							Cer	tifica	te of	Death			Reg. No.			
		1. Decedent's Nema (First, Mi	iddle, Last)									2. Date of De		Maria	3. Tin	ne of Death
	hysician	Harry Ernest	Fosta	r Tr								Month August	- 13.	1999		0350
	/Medical	4a Facility Neme (If not institu								4b. City, To	wn, or Lo	cation of Deat	1	ounty of Dea	-	-
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	neral		100	M 2DF			Yrs.	Months		Hours	Min.	8. Dete of Bir (Month, De	y, Year)	9. Bir	ountry)	ete or Foreign
Dire	ector	220-40-8941			5	4					Feb	ruary 6	, 194	15 Ma	rylan	<u>d</u>
2		Usual Residence of Decedant 10a. Stete 10b. Cou			10	Oc. City, Town	n or Loc	cation							10d Ineir	de City Limits
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5 5	be notified Director	10e. Street and Number						10f. Zi	p Code				10g. Citize	n of What Co	ountry?	
3 6	3 6	102 Montague	Lane						2192	1			Ur	nited:	State	S
dea	Funeral	11. Marital Status	-	12. Wes De		r in U,S.	13. V	Ves Dece			gin? (Spi	ecify Yas or No Rican, etc.)	- 14	. Race - Ame		ın,
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20 5	À	3 ☐ Widowed 4 ☐ Divore	ced	If Yes, G Yaar or	ive	1984	1	☐ Yes	2 X No	Specify:		Specify: White				
21215-0020 d within 72 hours after death with the Maryland glene.	deted by Funeral Director	15. Dece	dent's Educ	cation		16a.	Deced	ent's Usu	el Occup	pation			/Industry	1 1		
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aryian	5 C	H. Ernest Fos						-				ia Puro	-			
Maryiand d 2 abould be file th end Mental Hy	Line .	19e. Informant's Name/Ralation	onship (Ty)	pe, Print)		19b	. Mailin	g Addres	s (Street	end Numb	er or Ruri	al Route Numb	er, City or	Town, Steta,	Zip Code)	
Te, N	7.5	Laura J. Fost	er/ w	ife		10)2 M	onta	gue	Lane,	Elk	ton, Ma	rylar	nd 219	21	
SE TE	g	20a. Method of Disposition				20b. Plece of				ce)	10	/19/99		ation - City or	Town, Stel	le
Baitimore, Maryiand 2121 permit. Pages 1 and 2 abould be filed within Department of Heelth and Mental Hygiene.	, o	1 🖺 Buriel 2 □ Cremetion 3 □ Removal from Steta 4 □ Donetion 5 □ Other (Specify)														
Baitil Pemit. P	=	21. Signature of Funerel Service Licensee 22. Nama and Address of Fecility														
Be and	D D D	Hicks Home for Funerals, P.A.														
		Donald & Hules 103 West Stockton Street, Elkton, Maryland 21921														21921
		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. Approximet													Batween	
Physi	ician	shock, or heart feliura. List only ona ceuse on each lina.													Onset a	and Deeth
/Med		Immediata Cause (Final			C	ans.	1	G	1	sle	11					
Exam	niner	Immediata Cause (Final disease or condition resulting in death) Dua to (or as a consequence of):								24	,				1	
	ē -		a to (or as a t	conseq	uerioe or,											
petr +	for use as the burlet-transit		b	. ———	Dur	e to (or es a o										
. 0	x x	Sequentially list conditions, if any, leading to immediate	e to (or es a c	Misedi	uerice or,											
x 68760, entificate be assocuted	8	cause. Enter Underlying Cause (Disease or Injury that initiated events	< 0												1	1
287 Cate	\$ 5	resulting in death) Last			Due	to (or as a c	onsequ	ience of):							1	
× e i	N .		d													
O de de	in a															V. III.
ords, P.O. Bo	d by Physician	Pert II. Other algnificant cond	itiona con	tributing to d	death but n	ot rasulting in	the un	derlying	cause giv	ren in Part I	,	23b. Did	tobacco us	na contribut	a to the car	use of death?
O. a f	the state											10	Yas 2)28	No 3□P	robebly	4 Unknown
S, the	b d															
	9 7												an autops	y 24b.	Were euto	psy findings
()	should											perfe	ormed?		available p	
Hec Jaw	36 Z														of death?	
	page 2 should											10	Yes 250	No	1 Yea	2□ No
VISION Of VITAL IN Attending Physician: The refeeth.	director, page	25. Was casa refarred to med examiner?	ical							26. Place	of Deet	h (Check only	ona)			
Of V Physic	To To	1 Yes 254No	Н	ospital:	Inpatient	2□ ER/Qu	tpatient	3 D	OA Oth	er: 4 Ne	irsing Ho	me 5 Resi	dence 6	Other (Spe	ecity)	
0 4 5		27. Manner of Death		28a. Date	of tnjury		Tima of		28c. Injur Wor	y at		28d. Describe	how injury	occurred		
O HE S	the state	1 Metural 5 Pen 2 Accident inve	iding istigetion	(WO	ini, buy re	out)	njury	М		Yes 2	No					
S Person	# 5 E	3 ☐ Sulcide 6 ☐ Cou	ild not be emined	28e. Plec	e of Injury	At home, fe	rm, stre	et, fector	y, office			28f. Location (Number or R	Rurel Route	Number,
DIVISION Of VITAI or Attanding Physician: 1 after deeth. Disector: Attachie confiles	led in by the funeral Certification:	4 Homicide	Jiiiiiio G	build	ding, etc. (S	Specify)						City or To	wn, State)			
les sur	9 0	200 Codifies al Condi	de Physica	Inter- To the	- h t - t	fra a da da a	d a sib			a a data and	el =la =a	d - de			a stated	
80 4 F	pletely fil	(Check only 2 Medic	ying Phys al Examin	er: On the t	basis of exa	aminetion and	dor inv	estigation	et the tir n, in my o	ne, date an pinion, daa	d place, th occurr	end due to tha ed at the time,	date and p	no menner a lace, and du	e to tha cau	use(s)
DIVISION To the Hospital or Attending P within 24 hours after deeth.	Medical Certification: 1	one)	***	and mai	nner steted			1 44	- 12-				004 0	almand Add	th Carry	and a
O N	00	29b. Signature and title of gentifier 29c. License number 29d. Data signed (Month, Day										in, Day, Ye	ar)			
		7	700	di	++	Va	le	1 7	0/	849	0		8	117	99	
	7+11/4	30. Name and address of pers	ori wilo co	mpleted ceu	ise of death	(Item 23a) (Туре, Г	Print)	-							
/	d.								Cui	te 10	14 E	Elkton,	Mary	land 2	1921	
	State	Y. Patel, M.I 31. Dete filed (Month, Day, Ye	112		Registrar's							-21.0011/	y			
R	State egistrar	AUG 1 8 19	199	per		10.	19	DOW	N							
				/	r		-									

DHMH 16 Rav 6/95



Da	vid W. Fe		Maryland / I	Department of Certificate of			giene Reg. No.	7463			
Da		1. Decedent's Neme (First, Middle, Last)				2. Dete of De Month		3. Time of Death			
8	Physician /Medical	David W. Terguson,				Augus	t 16, 1999	7:25 PM			
	Examiner		•		4b. City, Town, or I						
	Funeral	2902 Brightseat Rd. #202 5. Social Security Number 6. Sex 7	. Age (In yrs. last bir	thday) If Under 1 Year			Prince G	-			
в	Director	214-60-2245 1\(\overline{\text{Q}}\) M 2□ F		Yrs. Months Days	Hours Min.	8. Dete of Bir (Month, Da Jan 23	y, Year) Co 3, 1952 Wash	nplaca (State or Foreign untry)			
	2 .	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		-		10d. Inside City Limits			
	days data	1 1 2 1	Lanh					1 Yes 2 No			
	with the Marylan is or 28a-f show be notified at Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	untry?			
	Th with		2	20706	<u>, </u>	United States					
02	or items 23s or infiner mast b	War. Ot .		13. Was Decedent of ff Yes, specify Cul		pecify Yes or No o Rican, etc.)	14. Reca - Ame Black, White Specify: B1 a	e, etc.			
9	hursi', o	3 Widowed 4 Divorced Year or Dat			16b. Kind of Business/						
21215-0020	다 원원 중	15. Decedent's Education (Specify only highest grade completed)		Give kind of work done life. DO NOT use retin	ipation a during most of wor ad)	king	160. Kind of Business/	nousiry .			
212	d within piens. If the Me	Elementery/Secondery (0-12) College (1-4	(or 5+)	Electricia	ın		Private				
Pu	2352 6	17. Father's Neme (First, Middle, Last)					Meiden Sumeme)				
Maryland	should no Men marks umarks		400	Adama Adda (Oraș	-	Newman		Fin Code I			
Ma	and 2 shy selfh and n 27 is ma er treum	19e. Informent's Neme/Relationship (Type, Print)		III.			er, City or Town, State, 2 Janham, Mary				
re,	-755	Angela Ferguson/ Wife 20e. Method of Disposition	20b. Plece o	1 Disposition (Name of ry, cremetory or other plants		Dete	20c. Location - City or				
Ë	Pages sent of int: if he iry or o	1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removel from St 4 ☐ Donetion 5 ☐ Other (Specify)	919	and Veterans	1.8	3/24/99	Cheltenham,	Md.			
Baltimore,	permit. Departr Imports any Inja	21. Signeture of Funerel Service Ligensee	1085	22. Name end Addr Alexande	ress of Fecility			007/7			
	THE REAL PROPERTY.	23a. Pert1. Enter the disease, or completetions that car shock, or heart failure. List only one ceuse on eer	used the deeth. Do	not enter the mode of dy	ing, such es cardiec	e/rorest or respiratory e	rest, Md.	20747 Approximete			
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	ei Zu	re D	isoro	ler	in	Intervel Between Onset and Death			
	executed in and ial-transit	As:	socia	tion 1	vith	Alco	holism				
	and and litran	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or es a	consequence of):							
8760,	ate be executed hysicien and the burial-transit dical Examin		Due to /or on o	annoquence of							
9	g phy as th	(resulting in death) Last	Due to (or es e t	consequence of):							
Box	death certific e attending pl ed for use as 1	d									
0.	ist the death certific d by the attending petached for use as Physician/Mex	Part II. Other algnificant conditions contributing to dea	th but not resulting li	n the underlying cause g	iven in Pert i.	23b. Dld	tobacco usa contributa				
9	igned by be detacted by Phy					10	Yas 2 No 3 P	robebly 4 Unknown			
Records,	r requir						ormed?	Were autopsy findings aveilabla prior to completion of cause of death?			
	The lew ate has be page 2 s					175		1 XYes 2 No			
Vital	certificate rector, par	25 Was case referred to medical			26. Place of Dee	oth (Check only	one)				
of V	Physicien: this certific ral director, To Be	Yes 2□ No Hospitei: 1 □ Inj		Apatient SD DOM			dence 6 Other (Spe	city)			
	Ang P. After the funeral funer	27. Menner of Death 1 Netural 5 Pending 28a. Dete of (Month)		Time of 28c. Injury	ury at ork?] Yes 2 ☐ No	28d. Describe	how injury occurred				
Division	if or Attending after death. Director: Atte d in by the func	2 Accident investigation 3 Suicide 6 Could not be 28e. Pleas	f Injury - At home, fe	M 1 [12.00	28f. Location (Street and Number or Ru	ural Route Number,			
2	tal or Attending P rs after death. al Director: After tied in by the funers Certification:	4 Homicide determined 200. Field of building		City or To	wn, Stete)						
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by ti Medical Certific	29e. Certifier 1 Certifying Physician: To the base one) 29e. Certifier 1 Certifying Physician: To the base one menne	is of examination en								
	within To the comp	29b. Signeture and fitte of certifier	٨٨	29c. Licer	nse number		29d. Dete signed (Mont				
		1 & Pertane	-,101	D o.c.	M.E.		August 17	, 1999			
	(6)	30. Name and address of person who completed cause	_								
		31. Date flied (Month, Dey, Year) 32. Reg	gistrar's Signeture	III Penn St	reet, Bal	timore,	Maryland 2	1201			
	State Registrar	AUG 2 0 1999	was d	1. Some	7						

DHMH 16 Rev 6/95



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death lan Month **Physician** GRAVES ugerst 11:07 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMORE hary land morre If Under 1 Year 24 Hrs. 5. Social Security Number 6. Sex . Aga (In yrs. last birthday) 8. Deta of Birth (Month, Day, 12 - 22 Birthplaca (Stata or Foreign Country) **Funeral** Deys Months Hours 1 M 2 F 213-14-7228 82 Yrs. **Director** Usual Rasidance of Decedent 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Tas 2 No Director Mo DALTIMORE CHERRY HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be SPELLMAN . 21225 Norms 23s USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 12 No If Yes, Give Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after next of Health and Mental Hygiene. ent if itsm 27 is marked other than "natural", or its 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER EDUCATION 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be SLATER SAMPSON WILSON NELLIE 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health important: If Item 27 Is 1363 SPELLMAN RO CHERRY HILL, MO WILLIAM L. GRAVES. HUSBAND 21225 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stete à WORTON, MD NCCOL 8. 19.99 4 Donation 5 Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Fecility 21620 Mo WALLEY FUNERAL HOME. CHESTERTOWN ev 23a. Parti. Entar the disease, or complications that caused the death. On not entar the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximeta Intarval Betwe Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) /Medical Examiner Physician/Medical Examiner 30 attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated except Due to (or as a conseq 40 EUSION that initiated events Due to (or as a consequence of) rasulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 CUnknown þ 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed page 2 s has 2 NO 1 Yas 2 No 1 Yas After this certificate 25. Was case rafarred to medical 26. Placa of Death (Check only one) 1 Yas Hospital: Inpatient Other: 4 Nursing Homa Medical Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Tima of 1 Natural 2 Accident 5 Panding investigation 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

P.O. 1 Division of Vital Records,

Box 68760.

Baltimore, Maryland 21215-0020

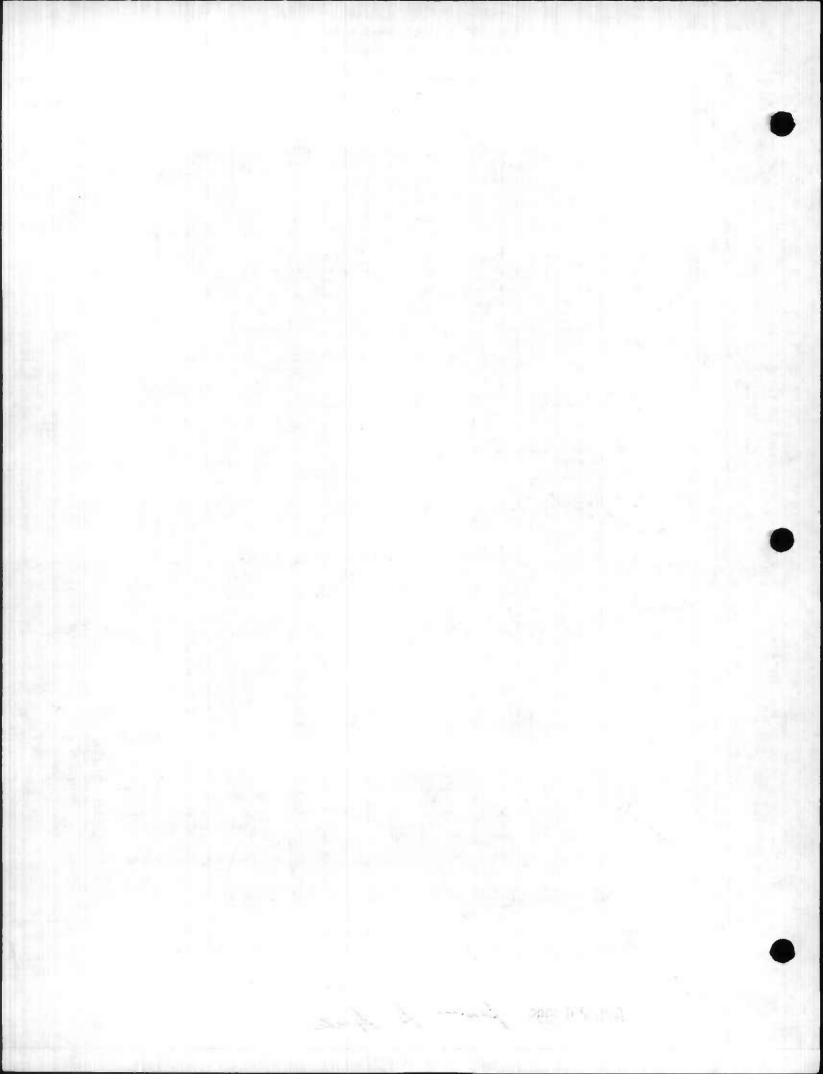
Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a Cartifier and mannar stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hrishan S. Greene

State Registrar 31. Date filed (Month, Day, Year) AUG 2 0 1999 32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 99991165

-			C	ertificate of	Death		Reg. No.				
	1. Decedent's Name (First, Middle, La	ist)				2. Dete of D Month	eeth Day	Yeer	3. Time of Death		
Physician /Medical	MARY L. HENIGI	EN GREEN				08		99	12:40 am		
Examiner	4e Facility Neme (If not institution, gir	re street and number)			4b. City, Town	, or Location of Dee	th 4c. County	of Deeth			
	2217 Afton Stree	t			Temple		Princ				
Funeral Director	237–58–0644		rs. last birthd 59 Yrs	Months Dev		Min. (Month, D	er 4,1939	9. Birthp Coun Nort	lece (Stete or Foreign try) h Carolin		
Mo ==	10a. State 10b. County	10c.	City, Town or	Location				1	0d. Inside City Limits		
Se-feb out et	Usuel Residence of Decedent 106. County Maryland Prince George's Temple Hills 106. Street and Number 2217 Afton Street 107 Street Street After Street 108 Street After Street 109 Citizen of What Country? 2217 Afton Street 11. Merital Status 11. Merital Status 11. Merital Status 11. Merital Status 11. Merital Status 11. Merital Status 11. Merital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rician, etc.) 14. Race - American Indian, Black, White, etc. 15. Decedent's Education 16. Decedent's Usuel Occupation (Specify only highest prede completed) 16. Decedent's Usuel Occupation (Specify only highest prede completed) 16. Elementery/Secondary (0-12) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 19. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20. Method of Disposition 19. Informant's Neme/Releationship (Type, Print) William Green/Husband 20. Method of Disposition 19. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20. Mentod of Disposition 19. Signaptine of Function 3 Michael Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21. Signaptine of Function 3 Michael Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 22. Name and Address of Facility 23. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Medician or respiratory arrest, Medician or respiratory arrest, Medician or respiratory arrest, Medician or respiratory arrest, Medician or Town, Stete or Street, Temple Hills, Maryland 207 23. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Medician or respiratory arrest, Medician or respiratory arrest, Medician or respiratory arrest, Medician or res										
or 2				10f. Zip Code			10g. Citizen of	What Coun	ntry?		
123a	2217 Afton Stree										
72 hours after death with the Maryland "natural", or flams 23s or 28s-f show folical Examiner must be notified at leted by Funeral Director	1 ☐ Never Merried 2 M Merried	Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give	1 U,S. 1	If Yes, specify Cu	ban, Mexican, P	? (Specify Yes or N Puerto Rican, etc.)	Bie	ck, White,	etc.		
d within 72 hours af giene. In than "natural", or in the contract fram.			100 D	and and the sel One	viation.		10h Kind of D				
nat nat			/G	ive kind of work don	e during most of	working	160. Kind of B	usiness/inc	dustry		
		College (1-4or 5+)			ive Ass				nt		
be filed of other avent,		·						ne)			
should be filed nd Mental Hygi marked other urratic avent, To Be Cc	James Henigen,	Sr.			Voic	e Lee Lea	ch				
0.00			et and Number o								
C = 0 =	William Green/Hus	Temple Hi	lls, Mai	rylan	d 20748						
8 5 - 5	1 ☐ Buriel 2 ☐ Cremetion 3 ☐	08/18	Dete 20c. Location - City or Town, Stete 08/18								
permit. Peges 1 er Department of Hee Important: If Item 2 any Injury or other once.				22. Name end Add	end Address of Fecility JENKINS FUNERAL HOME						
	7474 Landover Road, Landover, Maryla										
Physician					i	Onset end Deeth					
/Medical	diseese or condition	METASTATIO	SMALI	CELL LUN	G CANCE	R			1 1/2yrs.		
Examiner	resulting In death)	0.									
je la la la la la la la la la la la la la											
icate be executed physician end s the burial-transit	Sequentially list conditions, if eny, leading to immediate	b. Due to									
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ortificate be ing physicii e as the bu	thet initiated events resulting in deeth) Lest	Due to	o (or es e con	sequenca of):							
ath ce or us lan	Part II. Other significant conditions	ontributing to death but not	resulting in th	e undedving cause	tiven in Part I.	23b. Did	tobacco usa co	entribute to	the cause of death		
d by the detache		AN TO SHEET WAS TOOL	a ansarijing caasa j	FT-000-10-5-00-11-		Yes 2□ No		bably 4反 Unknow			
been s should							s en eutopsy formed?	ev	ere autopsy findings aileble prior to impletion of cause deeth?		
The lav						1	Yes 22 No	10	Yes 2□ No		
certificate rector, pa	25. Was case referred to medical				26. Plece of	Death (Check only	one)	1			
Physician: this certific ral director.	exeminer? 1 ☐ Yes 2 ☑ No	Hospitel:	ER/Outpa	tient 3 DOA	Whor	ng Home 5 Res		ner (Snecit	(v)		
Physician: To Be Continued in To	27. Manner of Deeth	28a. Dete of Injury (Month, Dey Year		e of 28c. In			how injury occur		,,		
tal or Attending P rs effer death. el Director: Affert led in by the funer: Certification:	1 XNeturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not to	OB Special Plans of Injury A		M 1	☐ Yes 2 ☐ No		(Street and Num	ber or Rure	al Route Number,		
or Attending effer death. Director: After d in by the fune ertification	4 Homicide determined	building, etc. (Spe	ecify)			City or T	own, State)				
To the Hospital or within 24 hours efter To the Funeral Dir completely filled in Medical Ceri											
thin thin the mple	29b. Signeture end title of cartifier	end menner stated.	-	29c 1 ico	nse number		29d. Date signe	d (Month	Dev. Year)		
0 1 × 0	250. Signature and title of cartifler	1/1	/						Doy, roury		
	un	1 nva	-1	043	3361		08/1:	2/99			
(19)	30. Name and eddress of person who Robert Siegel, M.				N.W. Sto	428 . Wash	ington-	D.C.	20037		
	31. Dete tiled (Month, Day, Year)	3 Registrar's Si		.a nvenue,	140117-202	120 / 11031	izing com,	5.0.	20051		
State Registrar	AUG 1 7 1999	Sque	6.	Am i	,						

State of Maryland / Department of Health and Mental Hygiene

		otato o marytana	Certificate of Dea	th	leg. No.							
		Decedent's Neme (First, Middle, Last)		2. Dete of Dea Month	th 3. Time of Death							
	Physician /Medical	JONATHAN GIBBS SR.		AUGUST	17,1999 4:20am							
	Examiner	4e Facility Name (If not institution, give street and number)	4b. City	, Town, or Location of Deeth	4c. County of Death							
		9319 WYATT DR.	LA	ANHAM	PRINCE GEORGES							
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday) If Under 1 Yeer If Un Months Deys Hou	nder 24 Hrs. 8. Dete of Birth urs Min. (Month, Dey	9. Birthplace (State or Foreign Country)							
	Director	241-48-3750 1X) M 2 F 64	Yrs.	OCT 1.	1934 NORTH CAROLINA							
	pus H		Town or Location		10d. fnside City Limits							
	Many Many Tor	MD PRINCE GEORGES LAN	HAM		1 N Yes 2 No							
	vith the Mar or 28a-f sl be noutled	10e. Streef and Number	10f. Zip Code	1	0g. Citizen of What Country?							
	3a o aga	9319 WYATT DR.	20706		UNITED STATES							
	r hems 234 ingrement	11. Merifel Status 12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or No-	14. Race - American Indien,							
21215-0020	by by	1 Never Merried 2 Married 1 Never Merried 2 Married 1 Never Merried 2 No. 54 Yeer or Detes: 8 - 58	1 ☐ Yes 2 ☒ No Speci		Black, White, etc. Specify: BLACK							
2-0	ed within 72 hours ygiene. Nor then "natural", rt, rr Completed by		16a. Decedent's Usuel Occupation	most of working	16b. Kind of Business/Industry							
2	within 7 ene.	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during r lifa. DO NOT use retired)									
2	T 5 L	12	CAPTAIN/ CORRECT		FED GOVT							
Maryland	Be avanta	17. Father's Neme (First, Middle, Last)			's Neme (First, Middle, Maiden Surneme)							
Yla	Merid To	ROBERT GIBBS		STELLE DAVIS								
Jar	0	19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Addrass (Street and Nu									
	f Health Ram 27 other tr	VIRGINIA GIBBS / WIFE	9319 WYATT SR. I									
Baltimore,	permit. Pages 1 s Department of He Important: If item any injury or othe once.	1XX Surial 2 Commetion 3 DRemovel from State Cen	ce of Disposition (Name of netery, crematory or other plece) STATE VETERANS	8-23-99	20c. Location - City or Town, Stete CHELTENHAM, MD							
Balt	permit. Departr Importu any inj	21. Signet(ine of Funeral Service Lipensee		S. POPE FUNERA								
1		23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,										
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Dua to (or a	C ADENOCHICI is a consequence of): Prz (WOWA, UN	KWOWW Z MOS							
68760,	flicate be executed physician and as the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										
Box 68	E 0.6	resulting in death) Last Due to (or e	s e consequance of):									
	death cer e attendir ed for use	Pert II. Other algnificant conditions contributing to death but not resulti	ng In the underlying cause given in P	Part I. 23b. Did to	obacco use contributa to the cause of death?							
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Records,	aw requisite been 2 should			24a. Was a perfor								
	The la			10 Y	as 2 HNO 1 Yes 2 No							
Ta	yelclan: The secreticate director, pag	25. Wes case referred to medical axaminer?	26. P	Place of Death (Check only or	na)							
of Vital	Z 00 Z	Mosnitel:	R/Outpatient 3 DOA Other: 4	Nursing Home 5 - Resid	ence 6 Other (Specify)							
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Division	tal or Attanding Piss after death. al Director: After tied in by the funeral Certification:	3 Suicide 6 Could not be determined 28a. Plece of Injury - At hom building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or Rural Routa Number, n, State)								
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	29a. Certifier (Check only one) 1 Certifying Physician: To tha besis of my knowle and menner steted.	edga, death occurred at the tima, date n end/or investigation, in my opinion,	e and place, and dua to the d death occurred at the time, o	ause(s) and mannar es stated. lata and place, and due to the cause(s)							
	Vithin Fo the comp	29b. Signeture end title of certifier	ber 2	29d. Defe signed (Month, Day, Year)								
		Sent Stand	08/18/99									
	(10)	30. Name end eddress of person who complated cause of death (Itam 2	3a) (Type, Print)	s un	20774							
		1221 WERCANTICE C	ANC CATEL									
	State Registrar	31. Date filed (Month, Dey, Year) AUG 1 8 1999	9. pouls									

DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		No.	2/46	1
	Physician	1. Decedent's Name (First, Middla, Last) CORRAD GARNER	2. Dete of Death Month	Dey 16 9	3. Tima of Decrease 3-35	th m
	· /Medical Examine	4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Local	ation of Death	4c. County o	Death	
	Α.	WASHINGTON ADVENTIST HOSPITAL TAKOMA PAR	RK	MONTGO	MERY	
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaer If Under 24 Hrs. (Months Days Hours Min.	B. Dete of Birth (Month, Dey,) SEPT 19,		9. Birthplaca (State or Fo Country) WASHINGTON	
10 1	/œ ×	Usual Residence of Decedant 10e. Steta 10b. County 10c. City, Town or Location			10d. Insida City L	imite
	th with the Marylay 23s or 28s-f show				1 TYPes 2	
	or 28s-f si	MD PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code	100	g. Citizen of Wi	net Country?	
	3a or			UNITED	CTATEC	
	fler death v	11. Maritel Stetus 12. Wes Decedent Ever In U.S. 13. Wes Decedent of Hispanic Origin? (Spec	ify Yes or No-	14. Race	- Amarican Indien,	
Maryland 21215-0020	*naturel', or thems	3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:	ican, atc.)	Specify:	White, etc. BLACK	
5-0	72 ho	15. Decedent's Education 16e. Decedent's Usuel Occupetion (Specify only highast grada completed) (Give kind of work done during most of working	16	8b. Kind of Bus	Iness/Industry	
121	filed within 72 ho Hygiene. ther than "nature ort, the Medical	Elementery/Secondary (0-12) College (1-4or 5+) Iiie. DO NOT use retired)			OVE	
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		BARBARA SELLARS GARNER/ WIFE 2104 LEWISDALE DRIVE, H	YATTSVI	LLE, MD	20783	
altimore.	8 5 2 0	20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place)	Dete 20		ity or Town, Stete	
Balti	permit. Page Department of Important: If eny injury or pnce.	21. Signature of Funeral Survice Licenses 22-Name and Address of Fecility Hope Funeral Home	e	7	.///	
00		23a. Pert 1. Enter the American Complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or head allure. List only one cause on each line.		FeresTi	Approximete	
٦	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYOCARDIAL (Consulting in death) Due to (or as a consequence of): CORD NARY ARTERY		CTGO	2002	264
68760.	licate be physicia s the bur	Ceuss (Disease or injury that initiated events resulting In deeth) Last Due to (or as e consequenca of):		54		
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۵	ras that the designed by the a		1 Tys	3500	3 Probably 4 Uni	known
Division of Vital Records. P.O.	The law requires that the deeth certificate has been signed by the attending page 2 should be deteched for use a Completed by Physician/M.		24e. Wes en performe		24b. Were eutopsy findi available prior to completion of caus of deeth?	
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	Within To the comp		29	d. Data signed	(Month, Dey, Year)	
	(0)	30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print) K.J. MMTHEW 6510 Kenilwork	Ave	2:0	do bro	Co.
	State Registrar	31. Dete filed (Month, Day, Year) AUG 1 9 1999 32. Registrer's Signeture				



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	Amend #'s	s 17.& 18. PGC 8-24	State of M	aryland	_	tment of H		and Menta		iene g	9	2.74.60
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	nytan .	10a. State 10b. County		10c. City, T	Town or Loca	ition					1	10d. Inside City Limits
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Maryland 21215-0020	S a constant	19a. Informant's Name/Relationship			_	Address (Street						
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38	and and and and and and and and and and	21. Signature of Funeral Service Lice	ensee h C		/							1 Home, Inc.
-	00268	Llander	1110	olar	16	61 Good	Hope	Road, S.	.E.;W	ashingt	on, D	o.C. 20020
	Physician	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause y one cause on each I	d the death. I	Do not enter	the mode of dyin	g, such as	cardiac or respi	iratory arre	est,		Approximate Interval Between Onset and Death
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of	7 5 7		Hospital: 1 Inpati	ent 2 ER	VOutpatient	3□ DOA Oth	er: 4 🔀 Nu	rsing Home 5	Reside	nce 6 Oth	r (Speci	fy)
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	To the Hospital or Attanding Physician 24 hours after death. To the Funeral Director: After to completaly filled in by the funeral completaly filled in by the funeral Medical Certification:	29a. Cartifier (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of	f examination	dge, death on and/or inves	ccurred at the tin stigation, in my o	ne, date and pinion, deat	d place, and du th occurred at th	e to the ca he time, da	iuse(s) and ma ite and place, i	nner as s and due t	stated. to the cause(s)
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	(2)	- Lachura	ce y all	Jn/	10			/		August,	0 3	1777
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	Cont	Richard A. Fars		2825 U. rar's Signature		t Koad,	rort	wasning	gron,	матута	ind 2	20744
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Willie Olander Holt 08 99 12 0045 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 1XM 2□ F Months 228-38-9542 64 Virginia Director March 16, Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **show** 12 Yes 2 No Directo 288-71 Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 U.S.A. 20785 6110 Montrose Road Norms 23a Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: Black. p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chef Private 12th Department of Health and Mental Hygis Important: If Isem 27 is marked other I any Injury or other traumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Pages 1 and 2 should be Olander Holt Inez Emerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dottie L. Holt/Wife 6110 Montrose Road, Cheverly, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 08/17 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 1999 Landover, Maryland 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 Landover Road, Landover, Maryland 20785 23a Fart1. Enter the disease, or composition shock, or heart failure. List only or cations that caused the gheth. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cade on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final PNEUMONIA disaase or condition resulting in death) Examiner Othenia Examiner arano physician and the burlat-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) 987 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, py gastrointestinal blueding 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was casa raferred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? Director: After in by the funer 5 Pending investigation n 24 hours after death.

Ne Funeral Director: After the further than the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homlcide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) Fo the Parish 2 29c. License number 00043492 29b. Signature and title of certified 29d. Data signed (Month, Day, Year) 70 08/18/99 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

WWW AM BOYCE PG HOSP 306/Hos Drive, Chevaly My 20785 300/Hosp

Registrar **DHMH 16 Rev 6/95**

State

31. Data filed (Month, Day, Year)

1 9 1999

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

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n	Examine	-	4e Facility Neme (If not institution, g	ive street and num	nber)			4b. (City, Town, or L	ocation of Deeth	4c. County	of Death	
7			Union Ho	spital						Elkton		Cer	ril	
Li	Funeral	\neg	5. Social Security N			7. Age (In yrs. las	st birthdey)	If Under 1 Y	ear If	Undar 24 Hrs. Hours Min.	8. Data of Birt	h	9. Birthpled	ce (Stete or Foreign
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	death with the Meryland rms 23a or 28e-f show r mat be recitied at		10a. Stete	10b. County		10c. City,	Town or Lo	cation					10d	d. Inside City Limits 1 XYes 2 □ No
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	CENL		Paul C.	Hammond,	Jr./ hu	sband	138 E	ast Hi	gh S	treet,	Elkton,	Maryla	and 219	921
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State of Maryland / Department of Health and Mental Hygiene

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	/Medica Examine		4e Facility Name (If not institution, gi	va street and numb	oer)			T	4b. City, To	own, or L	ocation of Dea	th 4c. Cou	nty of Death	
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	Funeral Director			Sax 7. 1□M 2XIF		775. last birthdey) 2 Yrs.	Months [Year	If Undar Hours	24 Hrs. Min.	8. Date of B (Month, D Februar	irth ley, Year) Y 9,1937		pplace (Stete or Foreign intry) Tyton, D.C.
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Yla		9	Charles Haynes								a Harr			
Jar	C/ 00 TO 00		19a. Informent's Name/Reletionship									ber, City or To		ip Code)
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Baltimore,	8 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ete	cemetery, cres	metory or other	er pla		1	08/24 1999	Landov		faryland
alt	permit. Pa Departmen Important: any Injury ance.		21. Signature of Funeral Servica Lice	nsee	1		2. Neme and /				AT ITOM			
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	hysician: To the be miner: On the basi and manne	is of exam	knowledge, deet nination end/or In	h occurred et vestigetion, In	the ti	me, dete er opinion, de	nd pleca, eth occur	end due to the red et the time	e ceuse(s) end e, dete end plac	menner es e, and due	stated. to the cause(s)
	To the Comp	3	29b. Signature end title of certifier			0	29c. t		sa number			29d. Date sig		
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	(6)		30. Name and address of parson who	completed cause	of death (Item 23a) (Typa,	Print) (5	AN	CHI	AND .	SURAN	IA	
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State of Maryland / Department of Health and Mental Hygiene 99 27172

			a /Final Adiabatta 1												
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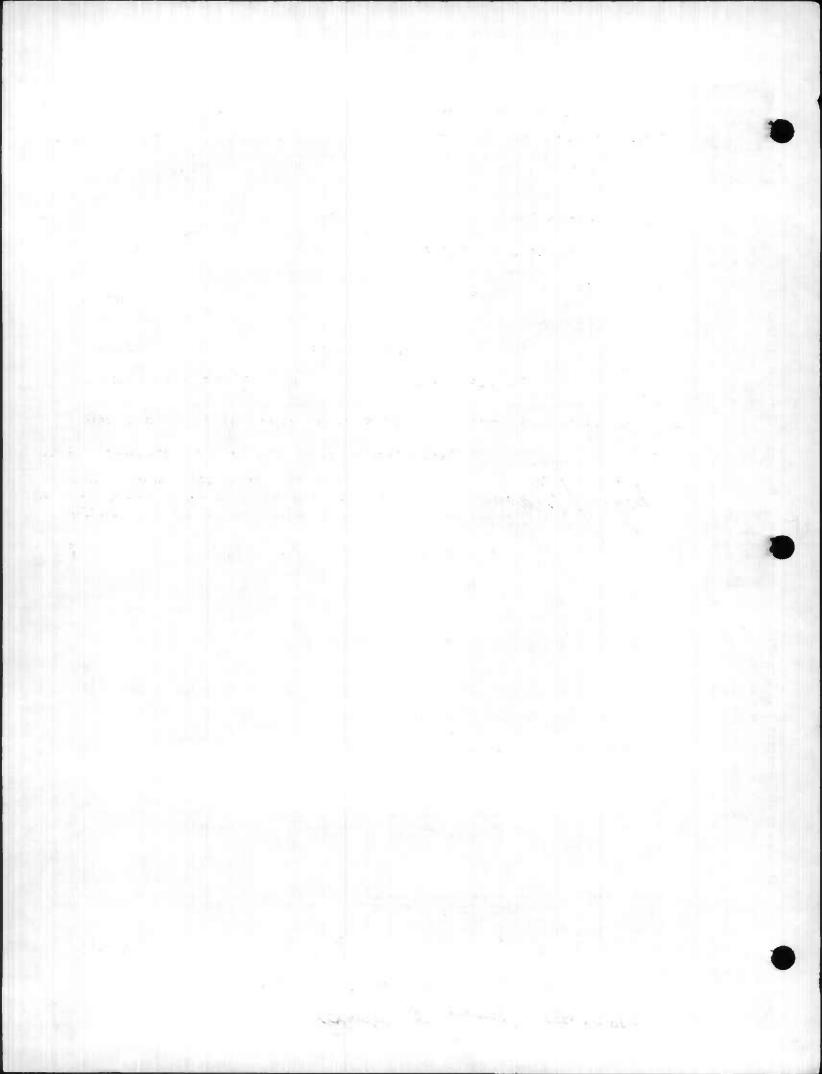
Charles . C. - - - 21, 1881 9 1 2011.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day **Physician** 2:35pm Frances E. Caldwell Haddox 8-15-99 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital Clinton Prince George If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Hours 232-56-7332 1□M 25 F Months Days Min. 63 Director West Va Usual Residence of Decedent with the Meryland 10d. insida City Limits 10a Stata 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Items 23s or 28s-f show other trsumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2€ No Suitland Director MD Prince George 10e. Street and Numbe 10f. Zip Coda 10g. Citizen of What Country? 27046 USA 4409 Rena Rd # 204 Funeral deeth 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. permit. Pegas 1 and 2 should be filed within 72 hours efter a Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines. Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du lifa. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Clerk 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Elenora V. Fleming Caldwell Julius 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 4409 Rena Rd #204 Suitland Md 27046 Robert Haddox(Husband) 20b. Place of Disposition (Name of camatary, cremetory or other place)
Shinnston Masonic Cem 8-19-99 Shinnston W.Va 20a. Method of Disposition 1 XBurial 2 Cremetion 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burnside Funeral Home 21. Signature of Funerel Sarvica Lice 607 S Virginia Ave Bridgeport West Va. asar the diseasa, a, of complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. 26 3 par Ckimate Interval Betwaen Onsat and Death **Physician** Immediete Cause (Finet diseasa or condition rasulting In death) 8 mo. cancer with Repatic hebastains /Medical Examiner Due to (or es a consequence of): Examiner physician and s tha buriel-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 88 950 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by t myo cardial infarction 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed Teendomonas aeraginosa baeterenna certificate has 2 0 No 1 ☐ Yes 2 ☐ No 1 Yes offer death.

Director: After this certifice 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Vio 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Netural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral DI completaly filled in 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certified A 13750 30. Name and address of person who completed ceuse of deeth (ttem 23e) (Type, Print) Swite 201 26 Woodyard Hoad 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 1 7 1999



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death Month **Physician** 1999 9:00PM Charles Jones Harris August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Undar 24 Hrs. 6. Sex 1 □ M 2 □ F 8. Dete of Birth (Month, Day, Year) Sept. 5 1 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Deys Yrs. 578-44-5451 64 **Director** 1934 Tennessee Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified at Maryland Prince George's Upper Marlboro 1 X Yas 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 144 Joyceton Terrace 20774 United States Funeral 14. Reca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🖾 No If Yes, Giva Yeer or Detes: 1 Never Merried 2 Namled 1 ☐ Yes 2 ☒ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) llth Electrician Private 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charlie Jones Maggie Sherley 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3809 Jay St., N.E. Clarice E. Harris - Wife #3; Wash., D.C. 20019 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition N Buriai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 8/19/99 Harmony Memorial Park Landover, MD 22. Name and Addrass of Facility 21. Signatura of Fonaral Service Licania Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Part1. Anter the disease, or complications that causes the doubt. Do not enter the mode of dying, such as cerdiac or respiratory errest, shoot, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediete Ceuse (Final disease or condition resulting In death) **Examiner** Examiner ai physician and s the burief-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Physician/Medical Due to (or as e consequence of) 88 USB Pert if. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by t gastiointes final hemorrhage 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to Completed 24a. Was en eutopsy completion of cause of deeth? 1 Yes 2 1100 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Dimpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accidant 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 👺 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) end manner as stated. 29a. Certifie edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. Licensa number 29d. Date signed (Month, Day, Year) 00054068 999 30. Name end address of person who completed caused doubt (Item 23e) (Type Pcint)

LERTIC Prince George Hospita 2. Registrer's Signature 31. Date filed (Month, Day, Yeer) AUG 1 7 1999 Registrar

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Baltimore, Maryland 21215-0020

requires that the deeth certificate be exec

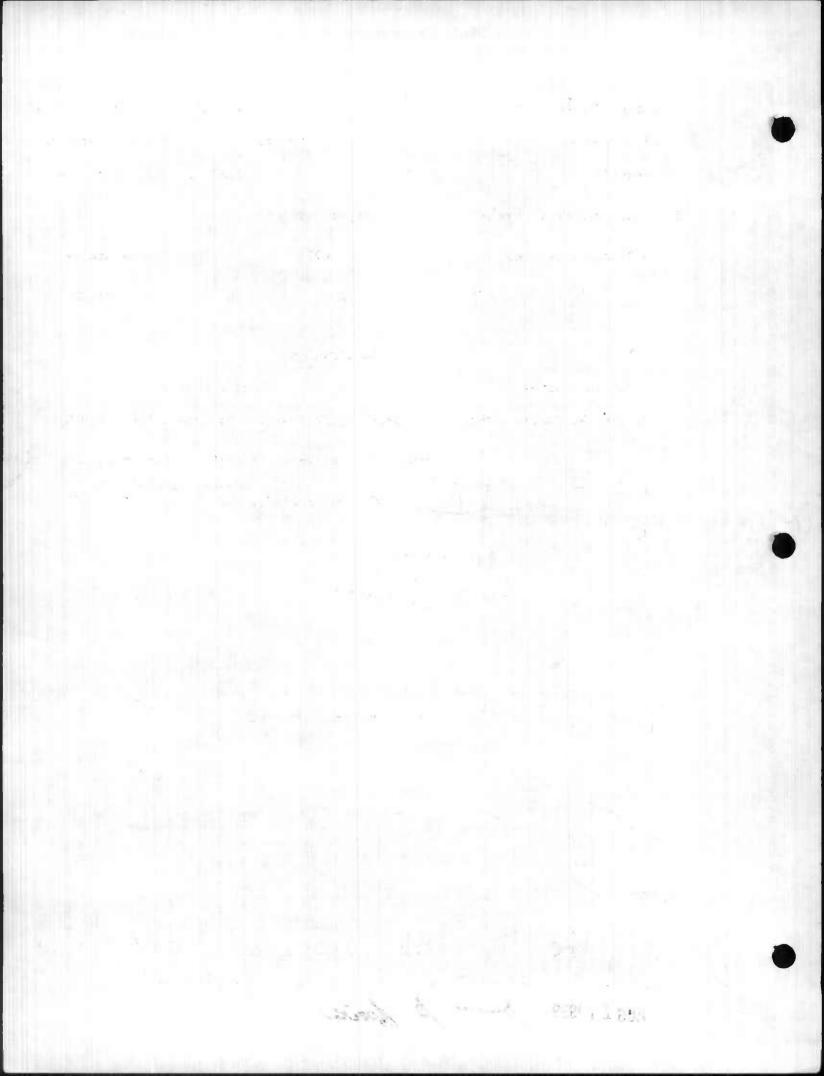
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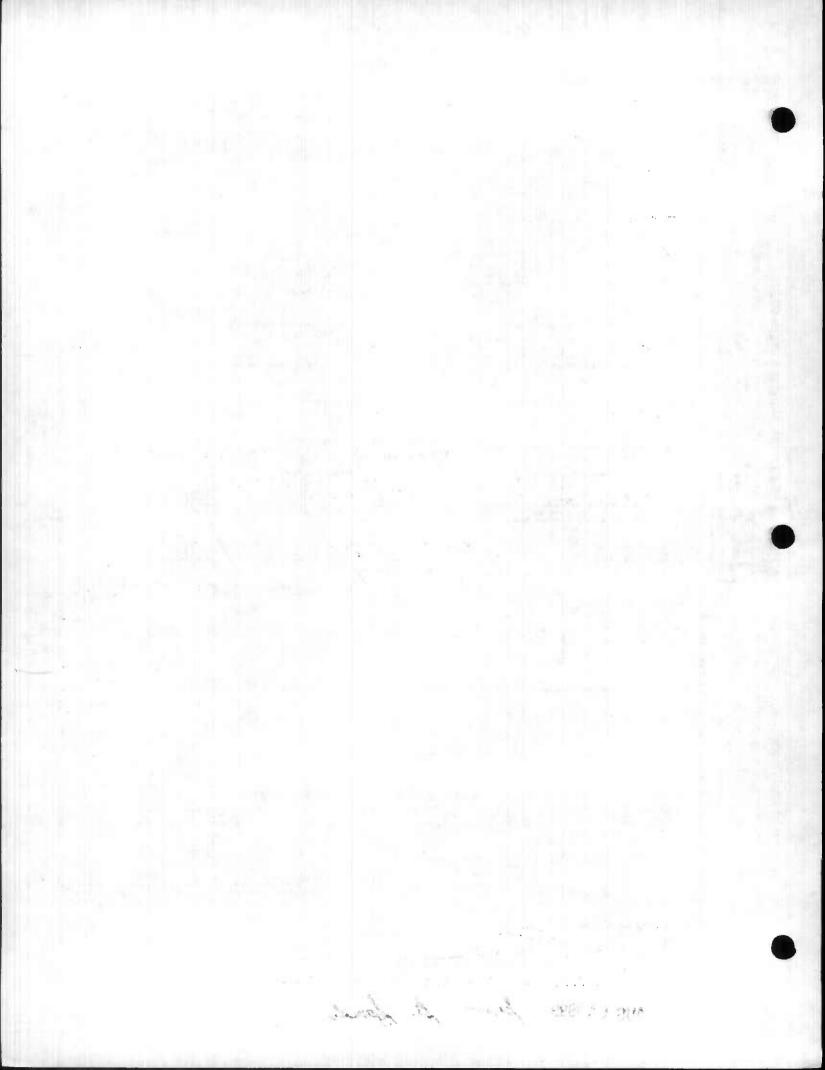
Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

			Otate of Maryla		rtificate of			Reg. No.	7 4	1415
	Physician	Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
3	/Medical	Dorothy C.	Hest	er			August	1		1:52 pm
H	Examiner	4a Facility Name (If not institution, give s				4b. City, Town, or L				
20.7		Washington Adven			V 41-4-4 V	Takoma			tgomer	2
	Funeral Director	5. Social Security Number 578-46-2842 Usual Residence of Decedent	M 212 F 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Jan. 22	y. Year) 2, 1936	9. Birthplac Country Washi	ce (State or Foreign
7	a le le le le le le le le le le le le le	10a. State 10b. County	10c. (City, Town or Le	ocation				10d	f. Inside City Limits 1 Yes 2 No
	or 28e-f	Maryland Prince G	eorge's	Cottag	ge City					
49	or 2	10e. Street and Number			10f. Zip Code			10g. Citizen of V		17
4	2 2	4003 Bunker Hill			207			U.S.		
Maryland 21215-0020	th and Mental Hygiene. The marked other than "natural; or frem 23s or 28e-f show treumatic event, the Medical Esaminer must be notified. To Be Completed by Funeral Director.	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	Specify	e - American k, White, etc	c.
2-0	ted fath	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	nation	kina	16b. Kind of Bu	siness/Indu	stry
2	yglene. her then 'naturn' n, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	11000	kind of work done DO NOT use retired	d)	any .			
2 3	Sept C	12	55.477	C.	lerk			Private		stry
Du S	fig.	17. Father's Name (First, Middle, Last)				18. Mother's Nam			(8)	
X S	New Stephen	Raymond A.	Chism			Lena	Sotzsk	У		
		19a. Informant's Name/Relationship (Typ. Lena Chism — Mothe			ng Address (Street Bunker H					code) Land 20722
0	8 - 5	20a. Method of Disposition 1X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	mount from Ctate	cemetery, cre	osition (Name of matory or other plac morial Park	c Cemetery (Date 08/17/99	20c. Location - Falls	•	
Balti	Department important: heny loudy o	21. Signature of Funeral Service Ucense		Ga	2. Name and Addre asch's Fu 739 Balti	ss of Facility neral Hon	ne, P.A.		e. MD	20781
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the de						. A	Approximate nterval Between
68760,		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Q To	(or as a consector as	quence of):	hear	o le	lisa	e	
Box	for un									
P. O.	igned by the estending be deteched for use a by Physician/Me	Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.	23b. Dld	tobacco use co	ntribute to t	he cause of death?
J. 1	2 5 E						10	Yes 2 No	3 Probe	bly 4⊠ Unknown
of Vital Records, P.O. Box	should eted							an autopsy pmed?	avail	e autopsy tindings lable prior to pletion of cause sath?
E E	4 6 6						10	Yes 2X No	10	Yes 2□ No
ta	certificate rector, per	25. Was case referred to medical				26. Place of Dea				
> 3	director To Be	avaminer?	ospitat: 1 tnpatient 2	□ FR/Outnatio	nt 3 DOA Oth	vor-		dence 6 □Oth	er /Snecitul	
Vision of Vita	s effecteeth. al Director: After this certificat ed in by the funeral director, pr	27. Manner of Death 1 ZNatural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Year)	28b. Time o	28c. Injur Wor			how injury occur		
-	re effect deeth. el Director: Affect led in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural I	Route Number,
a Hospit	within 24 hours of To the Funeral Di completely filled in Medical Cer	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	clan: To the best of my kees: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tire ivestigation, in my o	me, date and place, ppinion, death occur	, and due to the rred at the time,	cause(s) and ma dale and place,	inner as stai and due to ti	ed. he cause(s)
\$	Withir To the	29b. Signalibus and title of certifier	2		29c. Licens	e number		29d. Date signe	d (Month, De	ay, Year)
	(2)	VA Sont	Ca. 60		D1	.3339		August	16,	1999
	(3)	30. Name and address of person who cor				Rerigin 1	Heights	Marula	nd 20°	740
	State	Tsunie Chanchien, M 31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature "	Longs		HETRIICS:	Haryra	114 20	7-7-0
	Registrar	AUG 1 6 1999	1	A.	goods					

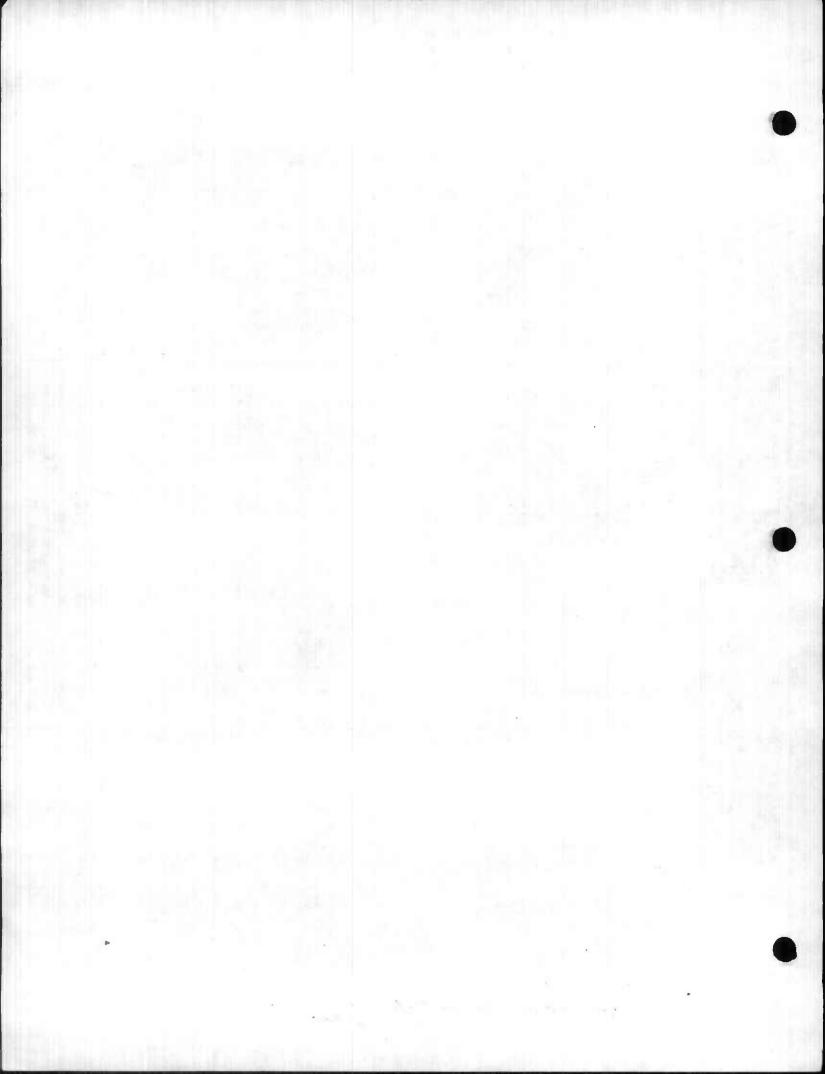
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** MERL HUTCHINGS August 70:44 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND HOSPITAL BALDMORE CIM BALAMORE CUM Unwersin | Months | Days | Hours | Min. | 8. Data of Birth (Month, Day, Year) | DeC . 19 / 5. Social Security Number 6. Sex 1 M 2 F 9. Birthplace (State or Foreign Country) 1930 Maryland 7. Age (In yrs. last birthday) **Funeral** 217-24-5335 68 Yrs Director Usual Rasidance of Decedent 10a Stata 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Maryland Directo Talbot Wittman 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ъ 22585 Pot Pie Rd. 21676 U.S.A. harne 23a Funeral 12. Wes Decedent Ever in U.S. Argied Forces? 1 (2/Yas. 2 ☐ No If Yas, Giva Yeer or Detas: Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 11 Marital Status 1 Never Merried 20 Married Saltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Pages 1 and 2 should be lifed within nent of Health and Mental Hygiene. Hit. If them 27 is marked other than 1 Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be George Hutchings Elsie Banta 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health as Important: If Item 27 is any injury or other trau P.O. Box 126, Wittman, Theresa L. Charters/Spouse MD. 21676 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 XCramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory 8-19-99 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. Finter tha disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or haart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner ENEBLO JASCULIAN physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. Dua to (or as a consequence of) 180 Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown Renar CELL CARCINOMA by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yas 2 ☐ No 1 □ Yas 2 □ No 25. Was casa rafarred to medical examinar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 ☐ Yas 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending invastigation To the Hospital or Atlanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edicai 29a. Certifian 🕰 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and manner as ststed. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Wa P12456 AUGUST 18,1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH STREET BALA mores USA 31. Data filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 9 1999 Registrar



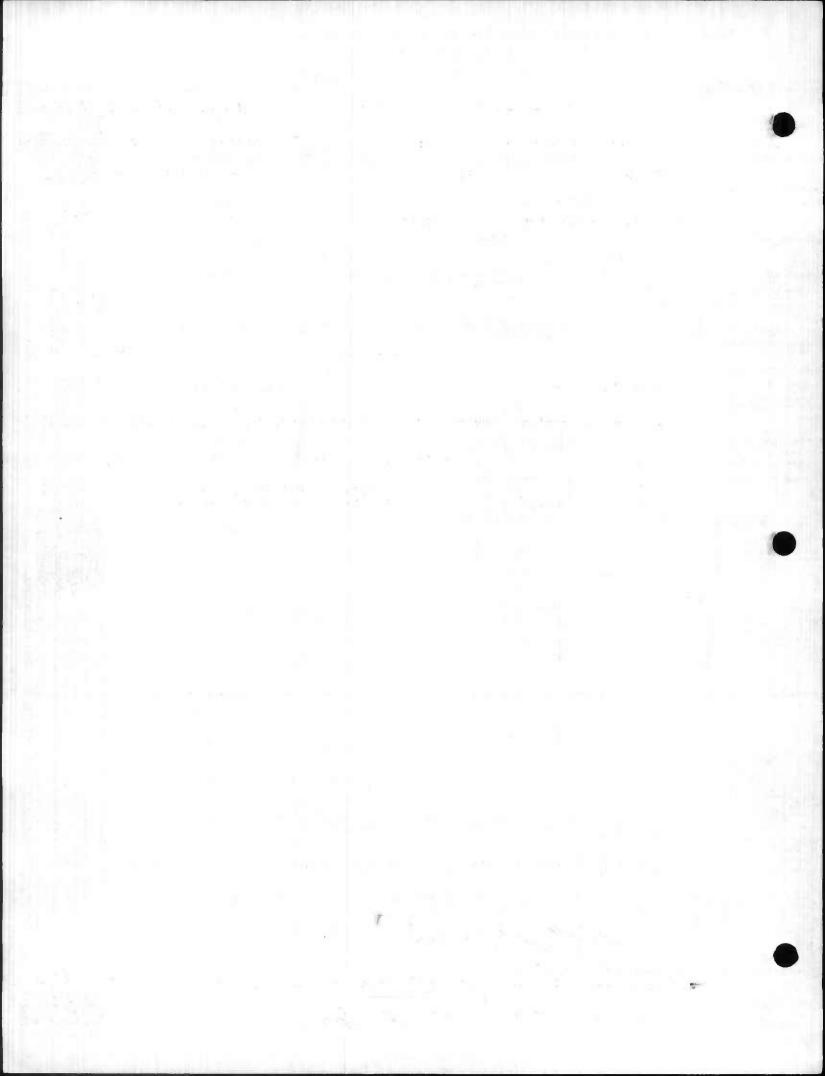
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Renia Louise Harrison august 1:50pm 1999 /Medical 4a. Fscility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester Hours Min. S. Dete of Birth (Month, Day, Year)

Jan 13,1946 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funerai** 1□M XX F Deys Yrs. Director 53 217-44-0909 Kentucky Usual Residance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits must be notified at XX Yes 2 □ No Director Maryland Dorchester Hurlock 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? Home 23a 203 Taylor Avenue US 21643 Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ā(M) No If Yes, Giva Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black White etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes XX No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced a filed within 72 hor if Hygiene. other than "natura vent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Poultry Plant 7 is marked other traumatic event, ti 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Malden Surname) Pages 1 and 2 should be ill ment of Health and Mental H-lant: If Item 27 is marked oth lary or other traumatic even Be James L. Brock Amanda Bullins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Samantha R. Harrison Daughter 901 Riverview Terr. Apt 2 St. Michaels, MD 21663 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 💢 remation 3 ☐ Removel from State 8/19/99 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 22. Name end Address of Fecility
Thomas Funeral Home, P.A. M Funeral Service Licenses 700 Locust Street Cambridge, Maryland 21613 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each lina. Approximate Interval Between Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting in deeth) Examiner Examiner physician end the burief-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as ate has been signed by the a page 2 should be detached to Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown þ 24b. Were sutopsy findings available prior to complation of cause of death? Completed 24e. Was an autopsy performed? certificate has 2 1 No 1 Yas Physician: director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Menper of Death Date of Injury Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Attending 1 Natural 2 ☐ Accident 5 Pending investigation il or Attending safter death. I Director: Aft 1 Yes 2 🗆 No 3 Suicide 8 Could not ba Place of Injury - At home, farm, atreet, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier 🟒 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end place, end due to tha cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and mennar stated. To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dey, Year) ans D 0050987 August 19, 1999 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Sheet Camb 31. Date filed (Month, Dey, Year) gar's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician SCHNOOR HENRY** ELIZABETH 1999 August 16 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5842 Newhart Mill Rd. Galestown Dorchester If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 214-07-7778 80 Yrs Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2/10 MD Dorchester Galestown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19973 5842 Newhart Mill Rd. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 25 No. If Yes, Give 14. Raca - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yas 22 No white þ 3/2 Widowed 4 □ Divorced Yaar or Dates: Completed 15. Dacadant's Education (Specify only highest grade completed) 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) homemaker own home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Martin Frederick Schnoor Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Tolley-daughter 2176 Wingate-Bishop Head Rd. Wingate MD 21675 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Borlal 2 Cremation 3 Removal from State 1 Borlal 2 Cremation.

Donation 5 Other (Specify) 8/19/99 Old Trinity Churchyard Church Creek, MD 22. Name and Addrass of Facility Thomas Funeral Home, PA 21. Signature of Funeral Service Licensaa 700 Locust St. Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. bladder mit assatie CA. Immediata Causa (Final disease or condition resulting in death) em Examine Sequentially list conditions, if any, laading to immadiate ceuse. Enter Undarlying Causa (Disaase or Injury that initiated evants rasulting In death) Last Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 1 Tyes 2/QNo 1 ☐ Yas 2 KNo 25. Was cese referred to madical examinar? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No To 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicide 29a. Cartifian Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titla of comition D 0050987 30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print) Nawa) 105

State Registrar

Funeral

Director

r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Hygiene.

2 should be 1 and Mental H

as 1 and 2 a of Health an Item 27 is

is marked

Important: If its any inju-Pages nent of h

Physician

/Medical

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Hospital or Attending P
 24 hours effer death.
 Funeral Director: After t

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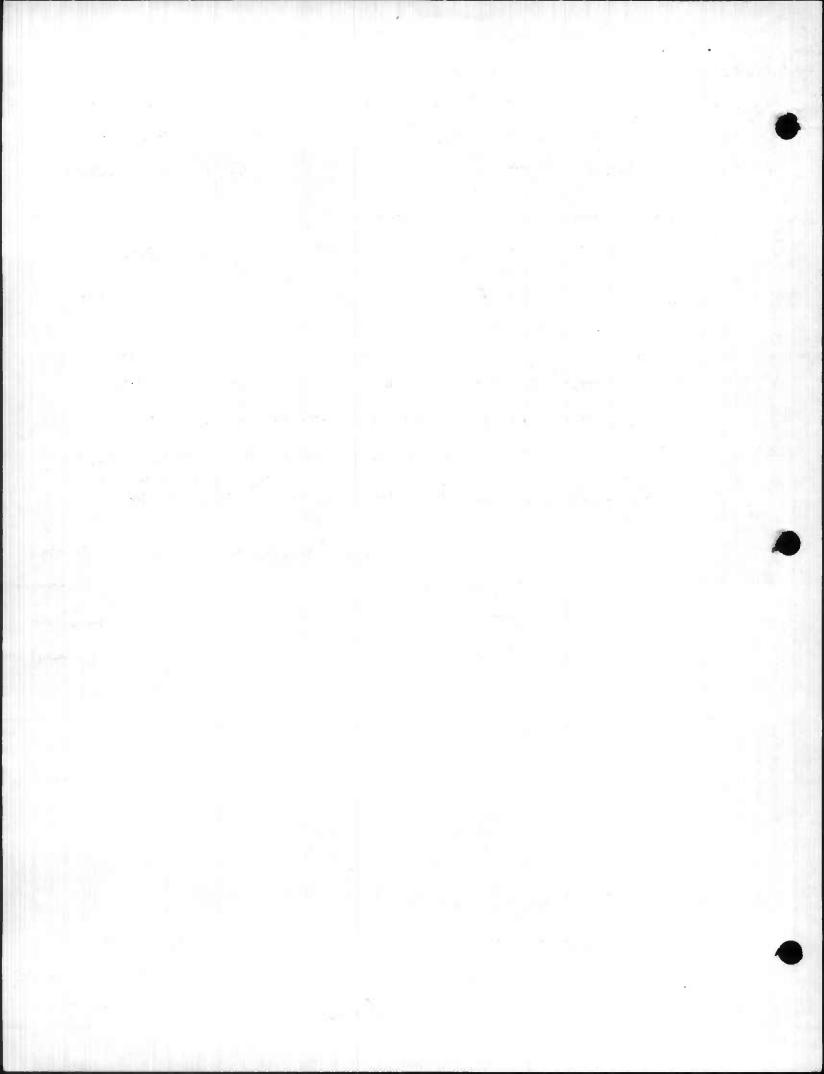
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Examiner

certificate be executed

Box 68760.

Division of Vital Records, P.O.



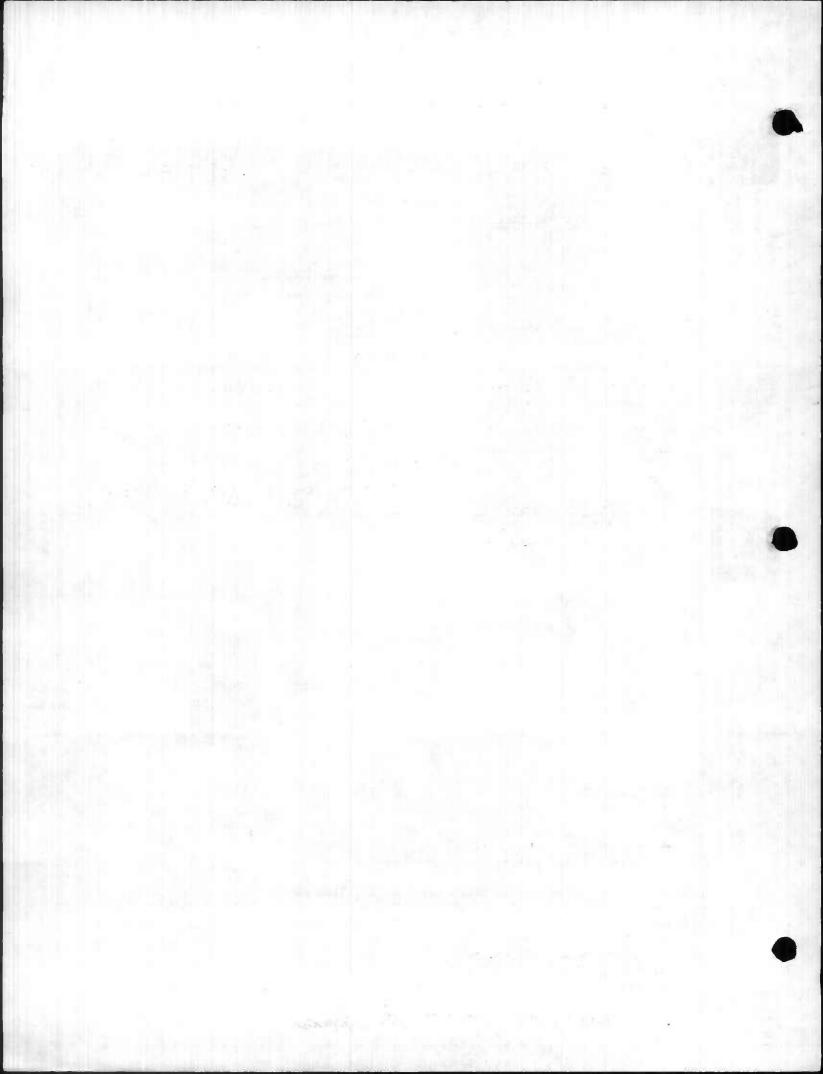
Registrar **DHMH 16 Ray 6/95**

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death

Physic /Med Exam

Funera Directo

ten 27 is marked other then "netural", or thems 23e or 28e-1 show other traumatic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be find within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or a social printy or other traumatic auce.

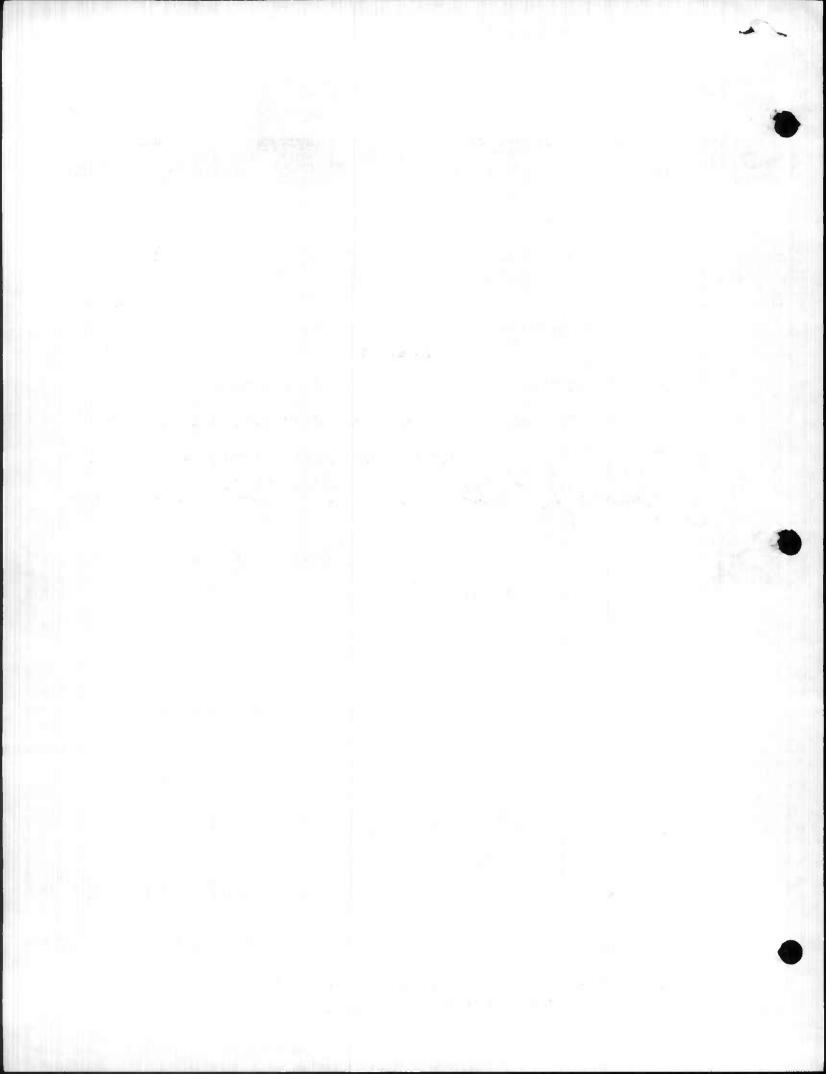
> Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

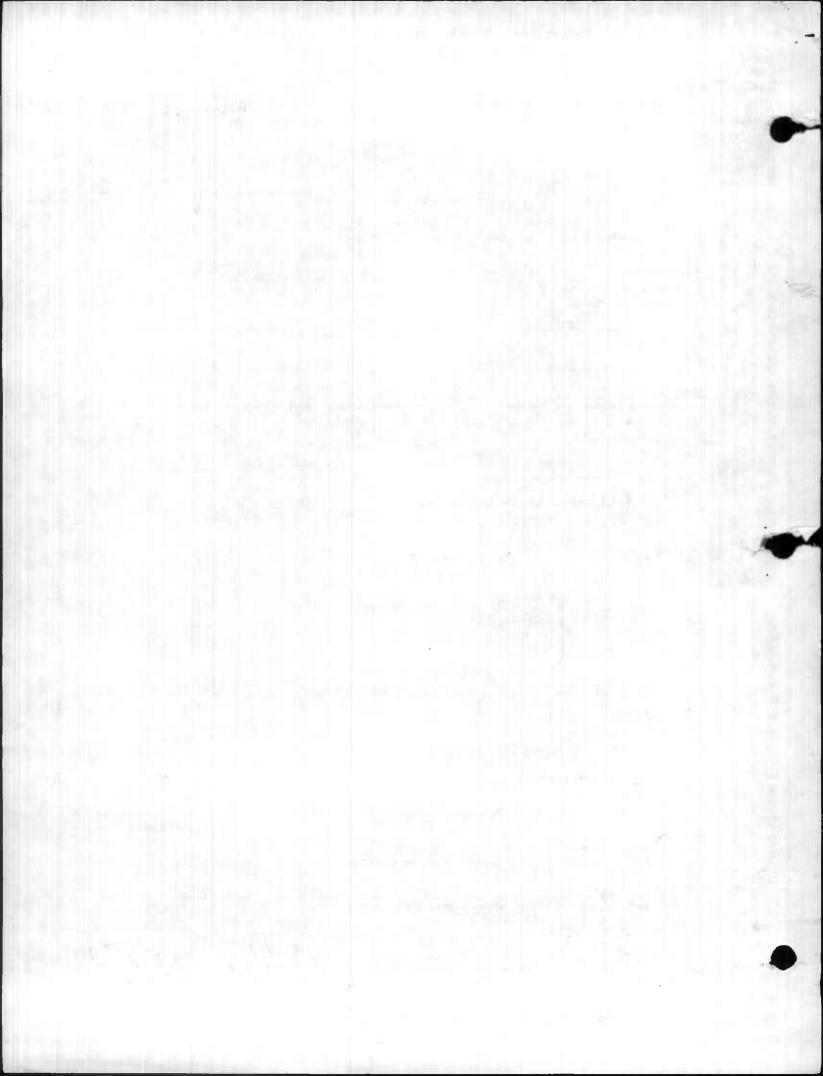
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buflat-transit Division of Vital Records, P.O. Box 68760,

	1. Decedent's Neme (First, Middle, Last)						2. Dete of De			3. Time of Deeth
ian	MARY ELIZABETH EMM	A HAMILI	ON				AUGUST	10, 19	99	9:00AM
ical ner	4a. Facility Neme (If not institution, give stre	eet end number)				4b. City, Town,	or Location of Deet			
	DORCHESTER GENERAL	HOSPITA	L			CAMBRID	GE	DORC	HESTE	R
	Social Security Number 6. Sex		e (In yrs. last		If Under 1 Y		irs. 8. Date of Bir			leca (Stata or Foreign
	215-01-9172 1 ¹	2 🗓 F	84	Yrs.	Months D	eys Hours N	APR. 2	th (Year) 1915	MARY	LAND
	Usual Residence of Decedant									
L	10e. Stete 10b. County		10c. City, To		tion				1	0d. Insida City Limits
cto	MARYLAND DORCHESTER		HURLO)CK						1 ☐ Yes 2 ☐XNo
Director	10e, Street end Number				10f. Zip Co	de		10g. Citizen of	What Cour	itry?
a l	5908 SHILOH-HURLOCK	ROAD			2	1643		US	A	
Funeral	11. Marital Status 12.	Was Dacedent I Armed Forces?	Ever in U,S.	13. Wa	s Decedent	of Hispenic Origin? Cuben, Mexican, Pu	(Specify Yes or No		e - Amaric	
	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 N If Yes, Give	lo lo		Yes 2X		arto rican, etc.)		ck, White,	etc.
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Be Completed	15. Decedent's Educat (Specify only highest grede co	ion om <i>pleted</i>)	16	Se. Deceder	nt's Usuel O	ccupetion one during most of	workina	16b. Kind of B	usiness/înc	dustry
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Be	17. Father's Neme (First, Middle, Last)						leme (First, Middle,	Meiden Sumen	10)	
P	WILLIAM JOHN STEVEN	S				DAISY	VICKERS			
	19e. Informent's Neme/Reletionship (Type,	-				reet and Number or				
	SHARON HAMILTON/DAU	GHTER				-HURLOCK	ROAD, HUR	LOCK, M	D 216	43
	20e. Method of Disposition 1 Deurlel 2 Cramation 3 Rem	ovel from State		of Dispositi tery, cremei			Date	20c. Location -	City or To	wn, Stete
	4 Donetion 5 Other (Specify)		EAST	NEW M	ARKET	CEMETERY	8/13/99	EAST NE	W MAF	KET, MD
1	21. Signeture of Funeral Service Licetage	20	1	22. N	leme end A	ddrass of Facility UNERAL HO	ME P O	BOY 20	7	
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17	Page. Enter the disease, or complicate those, or heart failure. List only one of	lons the caused	the death. D						T	Approximate Intervel Between
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sai Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events.		•							
cian/Medicai Examiner	resulting in daeth) Lest		Due to (or es	e conseque	nce of):					
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Completed								en eutopsy rmed?	eve	ere eutopsy findings eileble prior to mpletion of cause death?
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Be	25. Wes case referred to medical exeminer?	eitel.					Deeth (Check only o	one)		
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Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, :. (Specify)	farm, street	, fectory, of	fice	28f. Location (City or To		per or Rure	l Route Number,
edicai Certification:	29a. Certifier Check only one) Certifying Physicial Certifying Check only 2 Medical Examiner:	an: To the best of On the basis of end menner ste	examinetion e	ge, deeth or end/or inves	ccurred et the	ne time, date end ple ny opinion, deeth o	ece, end due to the courred et the time,	ceuse(s) end me dete and pleca,	enner es st	eted. the cause(s)
Me	29b. Signature end title of certifier				29c. Li	cansa number		29d. Date signe	d (Month,	Day, Year)
	Muneta					15541.		Augun	17,	1999
	30. Neme and eddress of person who comp VINODRAI MEHTA, M.D					RIDGE, MD	21613			

State Registrar

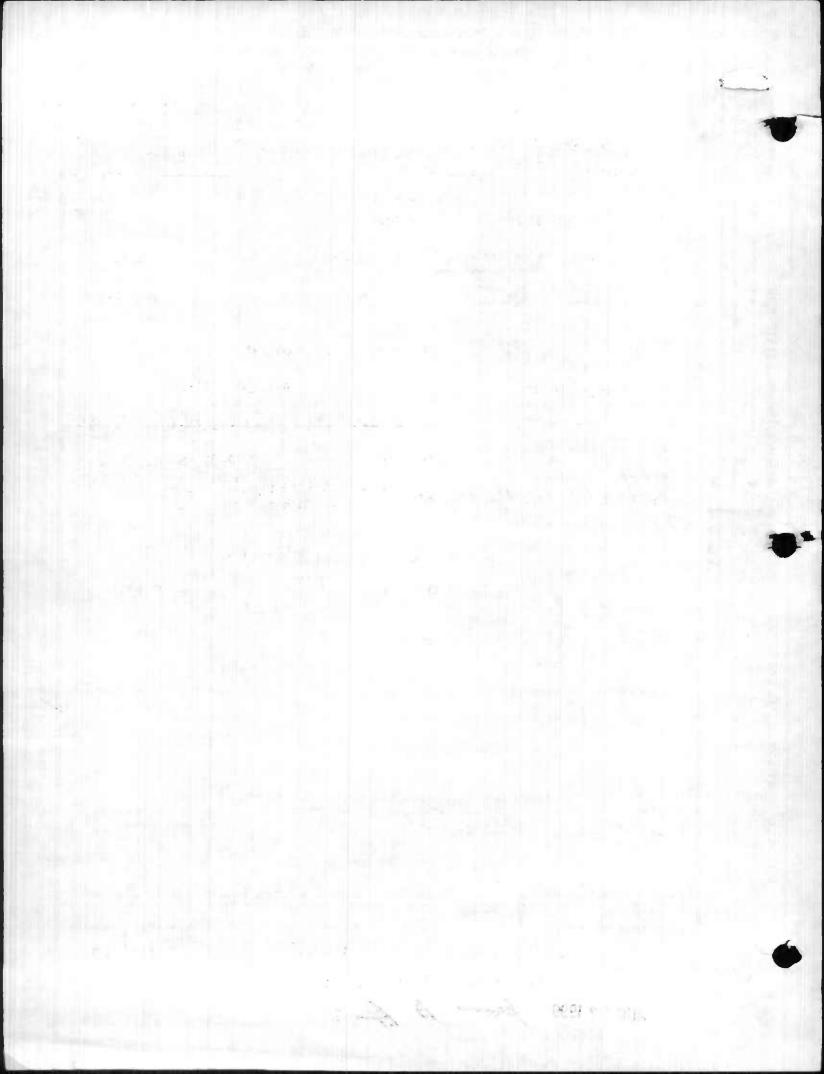


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		1. Decedent's Neme (First, Middle, L.	ast)						2. Dete of Dec	eth		3. Time of Death		
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	/Medical	4e Facility Neme (If not institution, gi	ive street end number)		- 4	4b. City. Toy	wn. or Lo	ocation of Deeth	4c. County		1.001101		
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	Funeral Director		1□M 2√□F	89 Yrs.	Months		Hours	Min.	8. Dete of Birt (Month, De May 4,	7, Yeer)	Coun	lece (Stete or Foreign try) Ord, NC		
		Usual Residence of Decedant			-			-	nay 4,	1710	Jani	ord, No		
	hend was	10a. Stete 10b. County		10c. City, Town or	Location						1	0d. Inside City Limits		
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	r items	1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give				en, Mexican	, Puerto	Rican, etc.)	Bie	ck, White,	etc.		
7	her, or	3 XWidowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:	7	1 ☐ Yes 2	XXNo	Specify:			Specif	y: B1.	ack		
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ā	Aente de lice	William J. Harr	ington				Mag	gie	McDouga	ald				
ary	should be made	19a. tnformant's Name/Ralationship	(Type, Print)	19b. Ma	ailing Addrass	(Straat	and Numbe	or Or Run	al Route Numbe	er, City or Town	State, Zip	Code)		
	and 2 aalth a n 27 ls	James A. Ivery	(Grands	on) 65	63 Zoy	sia	Ct.	Alex	kandria	, VA 2:	2312			
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	ortan Inlu	21. Signature of Fønerel Service Lice	<u></u>	occhese	22. Name an	d Addre	ss of Fecilit	v				110		
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. P.O.	The lew requires that the deeth certifica at the has been signed by the attending ph. page 2 should be detached for use as it completed by Physician/Med	SEPSIS.							10	Yes 2□No	3 Proi	pably 4 Unknown		
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<u>a</u>	ysician: The last certificate had director, page	HYPERTENSION							10,	ras 2 No	11	Yes 2 No		
<u>=</u>	clan: ector. Be	25. Wes case referred to medical axeminar?	Hospitel: 💥			Oth	or.		h (Check only o					
of	this crait dir.	1 Yes 2 No	1 Z Nnpat			A	4LI NU	irsing Ho	me 5 Rasio			y)		
L O	or Attending Ph sitar deeth. Director: After th in by the funeral	27. Manner of Deeth 1 Natural 5 ☐ Panding	28e. Dete of Inj (Month, D	ury 28b. Time 9 <i>y Year)</i> Injur		8c. Injur Wor			28d. Describe I	now injury occur	rred			
Division of Vital Records,	or Attendi efter deeth Director: A d in by the f	2 Accidant investigation 3 Suicide 6 Could not			М		Yes 2□I	No				10 1 11 1		
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	To the Hospital or Attending Physic Within 24 busins all other completely filled in by the funeral dire completely filled in by the funeral dire Medical Certification: To	29a. Certifier (Check only one) 1 Cartifying P 2 Medical Exa	hysician: To the best miner: On the basis of end mannar s	of examination end/or	eth occurred investigation,	et the tin , in my o	ne, dete en pinion, deel	d place, th occur	end due to tha red at tha tima,	causa(s) and <i>m</i> data and plece,	annar as s	tated. the cause(s)		
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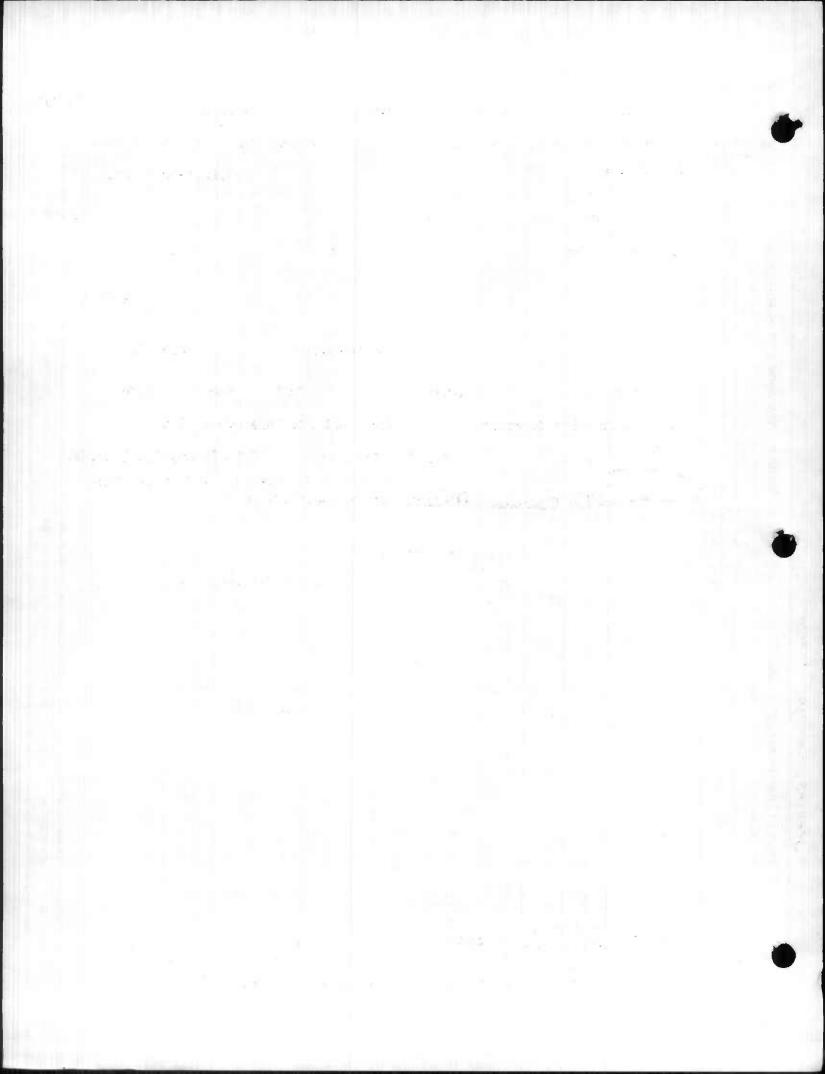
State of Maryland / Department of Health and Mental Hygiene Amend#'s 7.8. & 19b. Per FH PGC 8-26-99 cr Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** JOHNSON ERNEST 1999 **AUGUST** 5:35PM 11. /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGE PRINCE GEORGE COMMUNITY HOSPITAL CHEVERLY If Under 24 Hrs. 8 If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Dete of Birth Sept. **Funeral** 1**X** M 2□ F Months Deys Hours Min 28 192 71 Yrs. 228-42-4955 Director Virginia Usual Residence of Decedent the Marylend r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No Directo MD. Prince George Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7 is marked other than "natural", or itema 23a or traumatic event, the Medical Examinar must be it 4041- Warner Avenue #A-8 U.S.A. 20784 Pages 1 and 2 should be filed within 72 hours after death nent of Heelih and Mental Hygiene.
Int: If item 271s marked other than "natural", or itema 23 any or other traumatic avent, in "section Experiments". Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Washington Gas Empl. (Retired) 3rd 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Henry Johnson Frances Williams 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zio Code) 4041_Warner Ave.#A-8 Landover Md. 20784 19e. Informent's Neme/Reletionship (Type, Print) 9900 Caltor Lane, Fort Washington, Md. 20744
leca of Disposition (Neme of Dete 20c. Location - City or Town, Stete Betty K. Johnson/Wife Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition XXBuriel 2 Cremetion 3 Removel from Stete Department of Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) 8/17/99 Wash., D.C. Glenwood Cemetery 21. Signetura Funerei Service Licansee 22. Name and Address of Facility Bianchi Funeral Service c/o Hackett's Funeral Chapel, Inc. 234 Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner r ONATI ician and buriel-trans Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of) certificate be axec physician s the buriel Box 68760 Physician/Medical Due to (or es e consequença of) 80 980 ed by the a Pert II. Other stanificant conditions contributing to death but not resulting In the underlying ceuse given In Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? page 2 has certificate 1 ☐ Yes 2 M No. 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) axeminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Affer 1 Neturel 5 Pending aftar death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide ò filled in hours a Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated. Medicai completaly (Check only one) 2 Medical Examiner: In the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the To the To the 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 46776 12 9 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Terry Jodrie, M.D. 3001 Hospital Dr., Cheverly, Md. 20784 31. Dete filed (Month, Day, Yeer) Registrer's Signature State AUG 1 7 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

						C	ertificat	e of	Death		Reg. No.	23	Ca 1	400
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Examine		4e Fecility Neme (If n	ot institution, giv	e street and numi	oer)				4b. City, Town,	or Location o Deat	h 4c.	. County of	Death	
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Funeral Director		5. Sociel Security Nun 218–38–141		ex	. Age (In yrs. la 59	st birthde Yrs.	y) If Unde Months	Deys	If Under 24 H Hours M		sy, Year)		9. Birthpleca Country)	a (Stete or Foreign
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Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and it by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2.	To Be Completed by							U		24e. Wes	s en euto ormed?	psy	aveilat	autopsy tindings ble prior to letion of cause ath?
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or Al	E .	4 ☐ Homicide	determined	building	Injury - At hor , etc. <i>(Specify)</i>	ne, tarm,	street, tector	у, опіса		City or To	wn, Stete	3)	or nurar no	JULE MUNICES,
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ot w to) Contraction	29.W.	Wood	= les				01126	0	Au	411	99	, , , ,
		30. Neme and address	s of person who	completed cause	of deeth (Item	23e) (Typ	e, Print)							
		Howard	N.Weeks				Ave.	Hage	rstown,	Md.21742				
State	e	31. Dete filed (Month,	Day, Yeer)	999 32. Reg	intrer's Signet	ure	4	100	41					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0/10 ALLAN hnson EUVICKA HUS 6 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) County of Deat Spring mon Silver C1045 109 5007K1 If Under 24 Hrs. Date of Birth (Month, Dey, MARCH 6. Sex. 1 2 M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foreign Months Hours 18,1941 JAMACIA, WI 58 Yrs. 579-80-6405 Usuat Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYas 2 No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10608 GLENWILD RD 20901 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, Whita, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) SANITATION PERSONNEL GIANT BAKERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILFRED JOHNSON IVY GAYLE 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) CARMEN JOHNSON / WIFE 10608 GLENWILD RD SILVER SPRINGS, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State PARKLAWN CEMETERY 8-21-99 WHEATON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 21. Signature of ineral Service License 11315 LOCKWOOD DRIVE, SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Immediete Cause (Finat disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 42 Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

The law requires that the death certificate be executed

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peeu

Box 68760

P.O.

Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

natural, or items 23s or 25s-f

Hygiene.

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, importants if flew Z7 is marked other any injury or other.

hours after

Baltimore, Maryland 21215-0020

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Examiner Physician/Medical à Completed Be

Medicai

Division of Vital after death.

Director: After this certifications within 24 hours a To the Funeral D the Hospital

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physician and the burial-transit pendis pe del Certification: To

Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier onh 29b. Sighalure and title of certifie 0

25. Was case referred to medical examiner?

5 Pending

Investigation 6 Could not be determined

1 Yes 2□ No

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

31. Date filed (Month Pey Year) 99

M DME 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 2 / 0 / N BRECHER MO OWNE

28a. Date of Injury (Month, Day Year)

2. Registrer's Signature

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

medical

28c. tnjury at Work?

29c. License number

D00458

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

24e. Was an autopsy

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

20 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

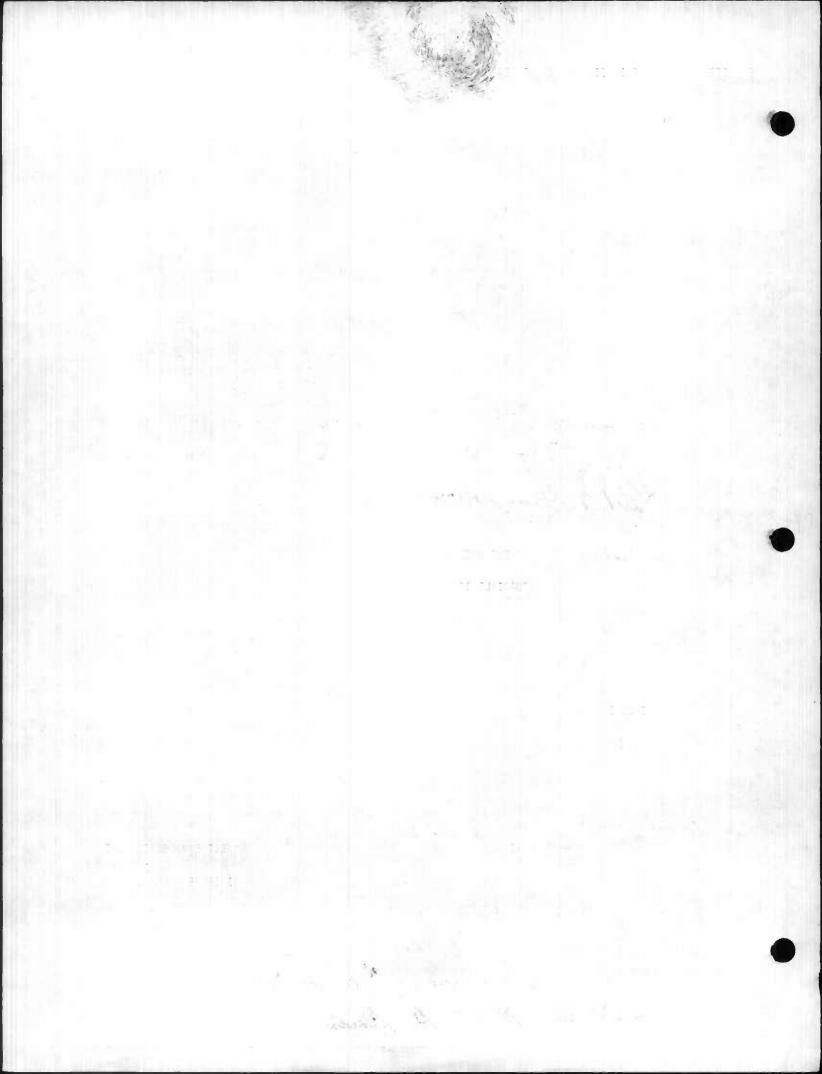
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29d. Date signed (Month, Dey, Year)

16,1999

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	#23 PART I		7	R MEO (yland / De 6775 C	ertifica	ate of	Death	2. Dete o		No.		3. Tim	e of Death
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lical iner	4a Facility Neme (4b. City, Town,	or Location of D	-	4c. County	of Death		
	Malcolm	Grow I	JSAF Medi	cal C	enter			Cli	nton		Pri	nce G	eorg	e's
1	5. Social Security N	Number	6. Sex		In yrs. last birthda	y) If Un	der 1 Yeer	If Under 24 Hours	Hrs. 8. Date of (Month	Birth	9ar)	9. Birthpl	lace (Sta	te or Foreign
r	577-82-20		1X M 2 □ F		22 Yrs.		50,0		March	7,	1977			on,D.C
	Usuai Residence of 10a, State	Decedent 10b. Count		1	Oc. City, Town or	Location						10	Od Inside	e City Limits
10	Maryland				*		rlbor	0						res 2 No
Funeral Director	10e. Street and Nur	mber				10f.	Zip Code			10a.	Citizen of \	What Coun	trv?	
O	6107 Ric	chmano	Terrace			1.5	207	7.2			nited		-	
Jera	11. Meritai Stetus		12. Was De	ecedent Eve	er in U,S. 13	. Was De			? (Specify Yes o uerto Rican, etc.	-	14. Rac	e - America	an Indian	٦,
þ	1⊠ Never Marri 3 ☐ Widowed		ried 1 Yes	Forces? s 2X No Give Detes:			pecify Cuba 22 No	Specify:	uerto Rican, etc.)		ck, White, e		
pet	/Coo	15. Deceder	nt's Education	ad)	16a. Dec	edent's U	sual Occup	ation	unding	168	o. Kind of B	usiness/Ind	lustry	
Completed	Elementary/Seco		st grade complete	a) (1-4or 5+)	life	DO NO	use retired	,	working					
Con			4		Fre	eland	ce Rep	porter			Journa			
Be	17. Father's Name		Last)						Name (First, Mic		den Suman	10)		
P	David A.				1				L. John					
	19a. Informant's Na					_			r Rural Route No					0770
	Wanda L.		ngton -		20b. Place of Dis	position (/	Vame of		ce Uppe		riboro	-		0772
	Burial 2	☐ Cremation	3 Removal from		cemetery, cr	ematory o	or other place		8/26/9					
	4 □ Donation 21. Signature of Fu			-					1			u, mu	•	
	N V	meral Service	Cooning	,		Alex	ander	S. Pop	e Funer	al H	omes			
	23a. Part1, Enter ti	ta.	Hava	< MI	085			_	ke/Fore			Md.	2074 Approxir	
dical Examiner	disease or condition resulting in death) Sequentially list con		a		e to (or es a cons							1		
EX	Sequentially list confidence in any, leading to improve cause. Enter Under Cause (Disease or	nmediate orlying			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 4	.,,					1		
e l	that initiated events resulting in death) I	3	c	Du	e to (or as a cons	equence o	rf):						1	
lan			0.											
Physician/M	Part II. Other signif	icant conditi	ons contributing to	death but n	ot resulting in the	underlyin	g cause giv	en in Part I.	23b.	Did toba	CCO USE CO	ntributs to	the cau	as of death?
Dy Fin	QUADRIPLE	GIA								1 🗆 Yas	2□ No	3 Prob	ably 4	Unknown
Completed									24a. \	Was an a performed	utopsy 3?	ava	ilable pri	sy findings for to of cause
E										Kes	2 🗆 No	150	Yes :	2 No
90	25. Was case reference axaminer?	red to medica						26. Place of	Deeth (Check o	nly one)				
	1 X Yes 2□		Hospitel: 1 E	Inpatient	2 ER/Outpati	ent 3	DOA Oth	er: 4 Nursir	ng Home 5 🗆 F	Residenc	e 8 DOth	er (Specify	1)	
	27. Manner of Death 1 ☐ Natural	h 5 ☐ Pendir	18.0.	e of Injury onth, Day Y	28b. Time Four hipry	Р	28c. Injur Wor		28d. Descr	ibe how	injury occur	red		
Certification:	2 Accident 3 Suicide 4 Homicide	6 Could determ	getion 8=19 not be lined 28e. Ple		6:00 - At home, ferm, s	M		Yes 2 🖄 No	28f. Location City or	on (Stree Town, S	OSED TO at and Numb state) WIN	DSOR P		Vum <i>ber</i> ,
ě	29a. Certifier	1 Certifyin	g Physician: To the	ne best of m	amination and/or	ith occurre	ed at the tin	ne, dete end pi pinion, death o	lace, and due to	the ceus	e(s) end me	enner es sta	ated.	se(s)
	(Check only one)	2 K Macucan	and me											
Medical Cer					2 2	1	29c. Licens	e number		29d.	Date signe	d (Month, L	Day, Yea	r)
edical	29b. Signeture and	Title of certifie	")	. C	luten	7		e number			Date signe Augus			
Medical	one)	Title of certifie	who completed ca	use of deat	luten h (Item 23a) (Typo treet, B) Print)	0	.C.M.E.	and 2120					

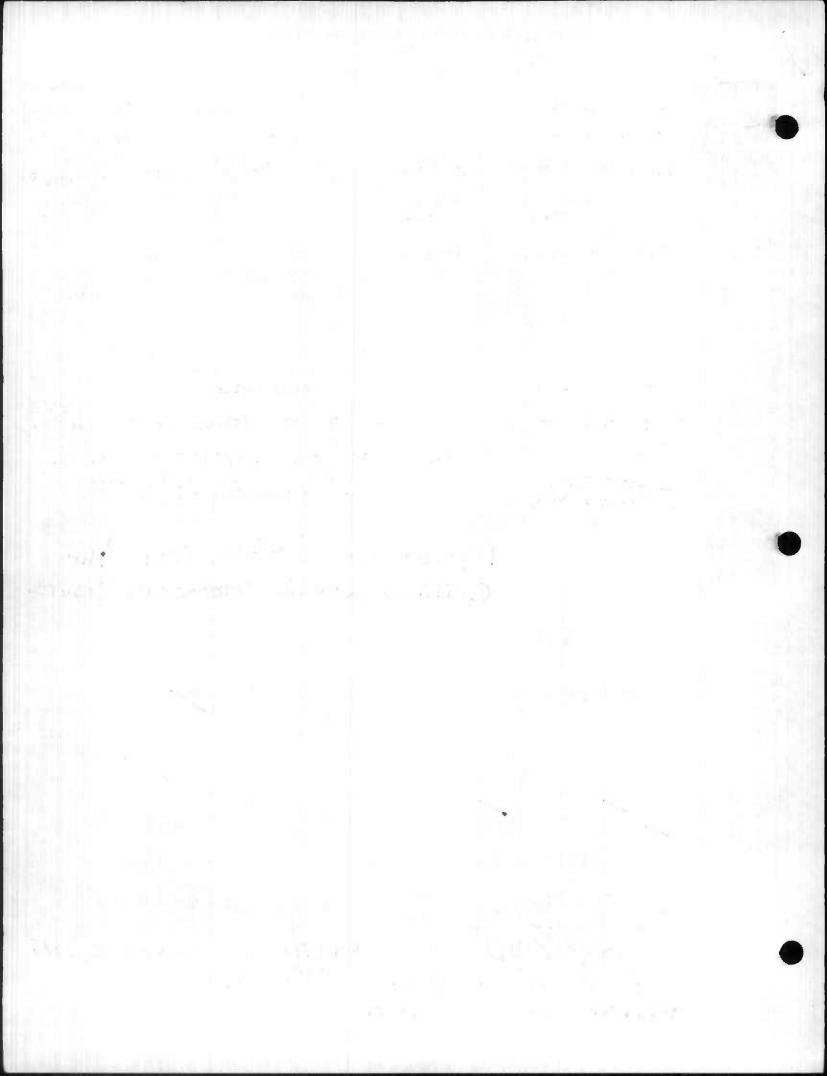


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Qata of Death 3. Time of Death **Physician** Day George E. Kline August /Medical 4a. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital **Elkton** Ceci1 If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

Months Days Hours Min. July 27, 1916 Reading, Pa. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 170-07-9838 1 M 2□ F 83 Yrs. **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Pa. Berks Reading Director 1 Yas 2 No 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 3249 Stoudts Ferry Bridge Rd 19605 USA Funerai . Was Decedant Evar in U,S. Armed Forces? 1 [XYas 2 □ No If Yas, Giva 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indien, permit. Peges 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter eny Injury or other traumatic event, the Medical Examera-Black White atc 1 Navar Marriad 2 Marriad 1 Yas 2 No Baltimore, Maryland 21215-0020 White þ Specify. f Yas, Giva Yeer or Detas: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Pastor Ministry 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) George L. Kline Anna Keller 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19605 19a. informant's Name/Ralationship (Type, Print) 3249 Stoudts Ferry Bridge Rd, Reading, Pa. Evelyn R. Kline 20b. Place of Disposition (Nama of cematary, crematory or other place)
Forest Hills Mem. Pk. 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 8/24/99 Reading, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Addrass of Fecility 259 E. Main St., Gee Funeral Home Elkton, Md. 23a. Part1. Entar tha di Msa, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or respiretory errast, shock, or haart fail Ms. List only ona causa on aach lina. Approximata Intarval Betw **Physician** /Medical Immediata Causa (Final diseese or condition rasulting in death) Examiner Stevosis Examiner physician end the burial-transit Sequantially list conditions, if any, leading to Immadiata causa. Enter Underlying Cause (Disaasa or injury that Initiated evants resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): 68 ettending 980 50 is signed by the et id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobaced use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ been sig 24b. Wara autopsy findings availabla prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No To the Mospital or Attending Physician: within 24 hours effer death. To the Funeral Director, Affer this certific funeral director, 25. Was casa rafarred to medical axaminar? 28. Placa of Daath (Check only ona) Pop Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 ☐ Panding Invastigation 1 Natural 1 Tas 2 No 2 Accidant 6 Could not be datamined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical completely 29b. Signeture end title of certifie 29c. Licansa number 29d. Dete signed (Month, Day, Year) 044716 august 20, 18 causa of daath (Itam 23a) (Typa, Print) Hig 31. Date filed (Month, Day, Year) AUG 2 4 1999 32. Ragistrar's State

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month 8/12/99 Mary Lee Kearse 9:54PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Nursing Home Hagerstown Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2□ F Director 219 60 2510 2/15/15 South Car. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director Washington Yes 2 No Md. Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23s 21740 USA Funeral 14014 Marsh Pike 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Stetus Pages 1 and 2 should be filed within 72 hours effer in and of Health and Mentel Hydine.
Int: If fem 27 is marked other than "natural", or fee inty or other traumatic event, the Medical Examine. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henrietta Williams Willie Conley 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 345 Montgomery St. #3P, Brooklyn, NY11225 Janie Darden-daughter 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Denial 2 Cremation 3 Removal from Stete
4 Donation 5 Other (Specify) Department of important: If any injury or once. Rose Hill Cemetery 8/17/99 Hagerstown, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility Watson Funeral Home St. Hagerstown, Md. 21740 24 W. Bethel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medicai Immediate Cause (Finel 1-200 Preumans disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 88 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Distity Mallity Centro verente 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed be should be deta Š The law requires 24b. Were autopsy tindings available prior to completion of cause of death? Casertin Hear Freden Be Completed 24a. Was an autopsy performed? . page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AULUST 13,1995 0 (8019 - OND MO 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print), 334 Hagerstown, MD 21740 301-739-7100

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 6

32. Registrar's Signature

21215-0020

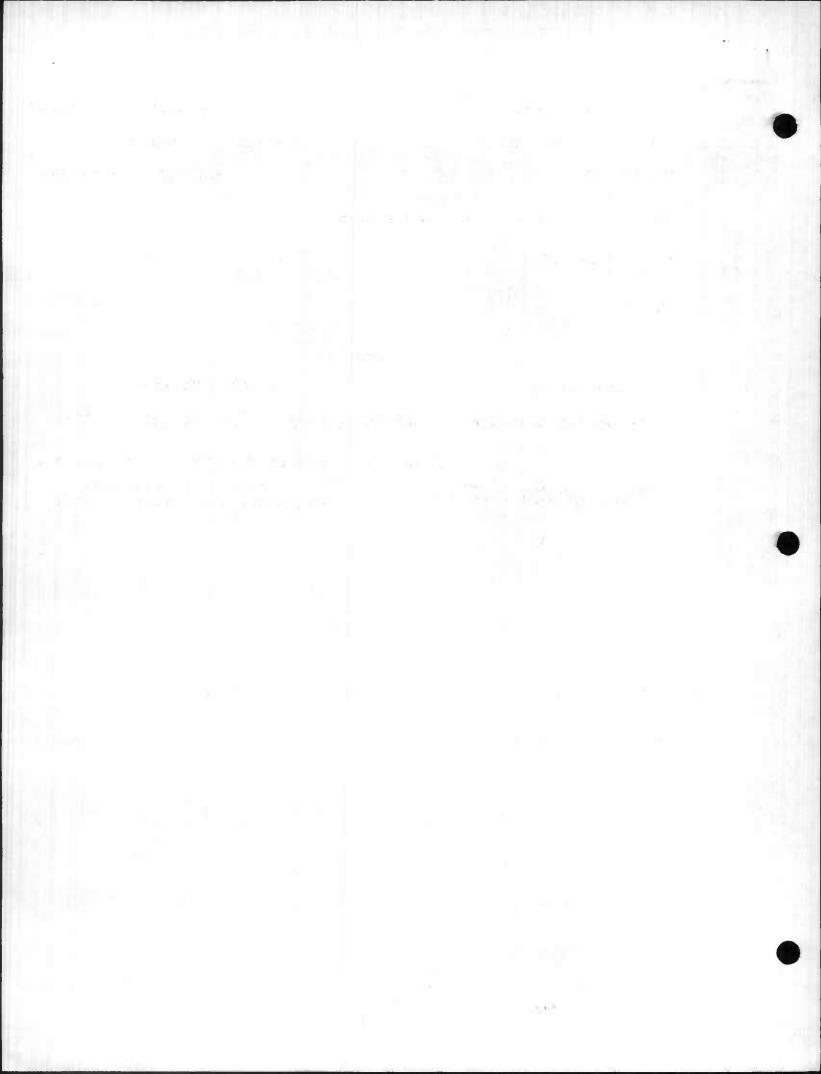
Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital



State of Maryland / Department of Health and Mental H	lygiene]	9
Certificate of Death	Dan No.	-

					State of	Maryla		partmen ertificat			and M	fental Hyg	iene 9 9	-2	
			1. Decedent's Nam	e (First, Middle, Li	est)							2. Dete of Dee			3. Tima of Death
Н	Physici				Paul A	. K1i	tsch					August	19, 19	99 ^{ear}	1:10 PM
\$	/Medic	_	4e Fecility Neme (i	If not institution, air						4b, City, To	wn, or Le	ocation of Death	4c. County		
	Examir	er								Perry	Poi	nt			
	Funeral		VA Maryland Health Care System 5. Social Security Number 6. Sex 7. Age (In yrs					ey) If Under		If Under	24 Hrs.	8. Dete of Birth 9. B			plece (Stete or Foreign
	Director		727-05-2	2293	XDM 2□F	72	Yrs	Months	Days	Hours	Min.	Nov. 13	,1926	Per	insylvania
-	D		Usuel Residence of	f Decedent											
	rylan		10a. Stete	10b. County		10c. C	ity, Town o	Location							10d. Inside City Limits
	Ma-Ya-Ta	Director	Maryland						В	altimo	re				t/XYes 2 □ No
	th th	Sire	10e. Street and Nu					10f. Zip				1	log. Citizen of V	What Cou	intry?
	23a		521 Alle	endale St	reet					21229			Ţ	I.S.A	
	n 72 hours after death with the Manyand "natural", or flems 23e or 28e-f show porcel Exercities than by notified at	Funeral	11. Maritel Stetus		12. Was Dece Armed For	dent Ever in I	J,S. 1	3. Was Deced	ent of	Hispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	e - Ameri ck, White	can fndien,
2	or its			ied 2□ Married	12 Yes	2 No		1 ☐ Yes					Specify		
2	ours	d by	3 Widowed	4 Divorced	Year or Da	ates: 1945	5-46						Optony	•	White
2	72 h	Completed	(Spec	15. Decedent's E	ducation rede completed)		16e. De	cedent's Usua ive kind of wo	l Occu	pation during mos	t of work	ing	16b. Kind of Bi	usiness/Ir	ndustry
7		mpi	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)			ork done during most of work use retired) ical Engineer				Government		
Z	T3 Co. No.		17. Father's Name	(Circl Middle Lee	Four Ye	ears	ľ	siectri	cai			e (First, Middle,			ment
ž	S a b S	Be	17. Father's Name		es J. Ki	litsch				rgetta M					
Ž	d 2 should be h and Mental 7 is marked o traumatic eve	P	19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route											in Contol	
Maryland 21215-0020	2 8 8 8		Leo A. Kl					_				nersvill	-		64-1442
	of Haalth Rem 27		20a. Method of Dis		, , ,	20b.	Place of Di	sposition (Ner	ne of				20c. Location -		
Baltimore,	S o L		Buriel 2	☐ Cremetion 3 [5 ☐ Other (Speci		State S1		n No.2			8				Pennsylvania
Ball	permit. Pag Department Important: Il eny injury o		21. Signature of Fu	uneral Service Lice	711 LFX	NOV. S	r.	Lee A. Perryv	Pa	tters	on &	Son Fun	neral Ho 3-0188	ome	
	Physician		23e. Part 1. Enter to shock, or hea	he diseese, or con int failure. List only	mplicetions thet ca y one ceuse on ea	aused the dea ach line.	th. Do not						rest,		Approximate Interval Between Onset and Death
	/Medical		tmmediale Ceuse diseese or condition		Pne	eumonia									1 Month
	Examiner		resulting in death)		a			sequence of):							
	7 2	ner													
	daath certificata be axecuted a attending physician and of for usa as the burial-transit	Examine	Sequentially list co	enditions,	b	Due to	or es a con	sequence of):							
o	an a	Ä	Sequentially list co if any, leeding to in cause. Enter Under	eriving I										i	
8760,	ha bi	dicai	Ceuse (Disease or thet initiated events resulting in deeth)	S	C	Due to (or as e con	sequenca of):							
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P.0.	as that tha daa igned by tha at be datached to	Physician/Mec	Pert II. Other signif	ficant conditions	contributing to de	alh but not re	sulting In th	e underlying o	ause g	iven In Part I	l.				to the causs of death?
ecords,	aw requiras t is been signe 2 should be	pieted by										24a. Was e		9	Vere autopsy findings vailable prior to completion of cause f death?

Be

Medical Certification: To

Com

To the Hospital or Attending Physician: Tha is within 24 hours after death.

To the Funerei Director: After this cartificate ha complately filled in by the funeral director, page. Division of Vital Re

KNOWN TO PHYSICIAN

5+1VA

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner as stated.

| Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to tha cause(s) and menner stated.

28c. Injury at Work?

1 Yes 2 No

29b. Signature end title of certifier

25. Was case referred to medical exeminer?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Menner of Deeth

1 Netural 2 Accident

3 Suicide

29e. Certifier

4 Homicide

29c. License number D16608

29d. Dete signed (Month, Day, Year)

August 19, 1999

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

ZINO

26. Plece of Deeth (Check only one)

Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how Injury occurred

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

VA Maryland Health Care System, Perry Point, MD 32. Registrar's Signature KAM-KEN LEUNG, M.D., 31. Date filed (Month, Dey, Year,

Registrar

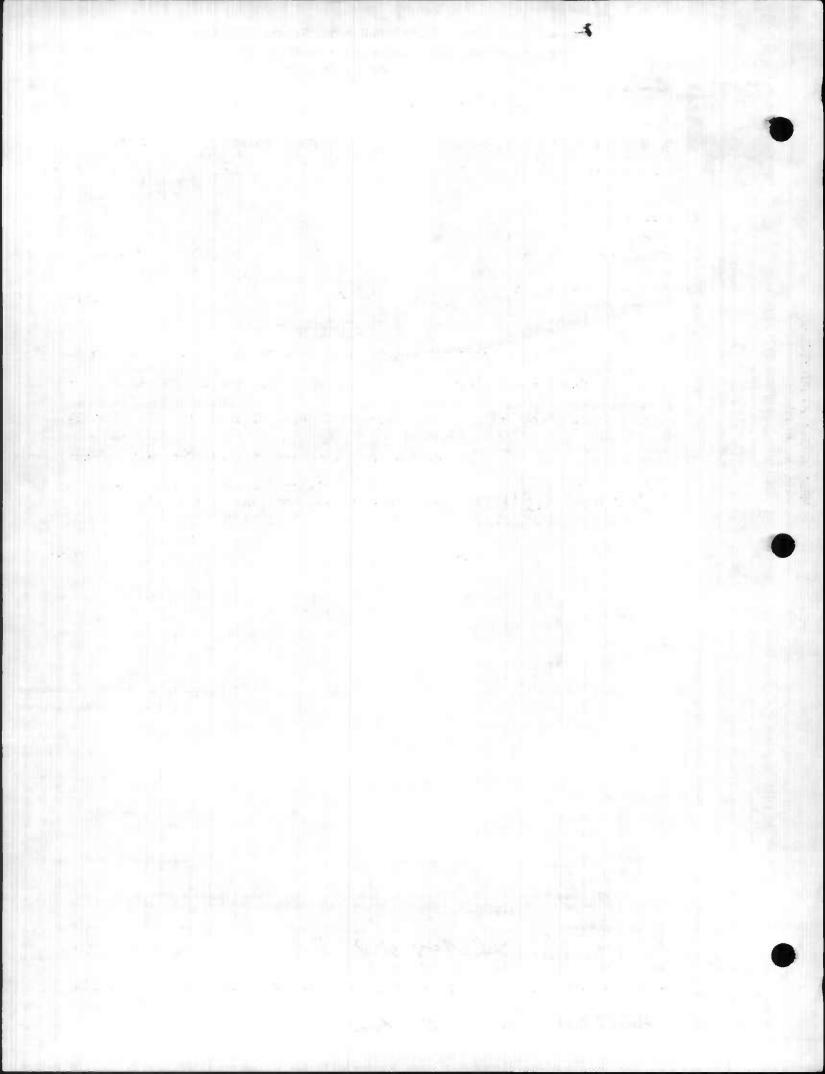


1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Pleca of fnjury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of finjury

28e. Dete of Injury (Month, Dey Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of N	narylano		rtment of t		Mental Hy	rgiene Reg. No.	19 2	7489
	Physic /Medi		1. Decedent's Name (First, Middle Ka Yher! N	e Kil	lle bro	ew			2. Dete of De Month	P Dey/7	Yeer 99 3	5 35 Am
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	show at st		Usuel Rasidence of Decedent 10a. State 10b. County		10c. Cify,	Town or Loc	ation				10d.	Inside City Limits
	death with the Meryland ms 23e or 28a-f show	tor	District of Co.	lumbia		Wash	nington					1 Yes 2 No
	ith the 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizan of	Whet Country?	7
	ss 23e		3329 Alden P		t Ever In II C	12 14		0019	Canality Van and		State	
5-0020	or its	by Funeral	11. Marital Stetus 1 □ Naver Married 2 □ Merr 3 □ Widowed 4 ☒ Divorced	If Ves Give	?] No	- If	Yas Decedent of P Yas, specify Cub		Specify Yas or No rto Ricen, etc.)	Specify	ce - Americen I ck, Whita, atc. y: Colo	
2121 d within giena. r than "		Be Completed	15. Decedent (Specify only highest Elementery/Secondary (0-12) 1 2 t h	t's Educetion st grada complated) College (1-4or		(Give k life. D	O NOT use retire	during most of wo d)	orking	16b. Kind of B		
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altimore,	6 = 5		20a. Method of Disposition 1 Buriel 2 □ Cremation 4 □ Donetion 5 □ Other (Sp		e cen	netery, crem	ition (Neme of etory or other ple Baptist		Dete 8/24/99	20c. Location ·		
Balt	permit. Pa Depertman Important: any injury once.		21. Signature of Funerel Service I	Licensee	7 11	22.	Name end Addre		tewart I			20019
1	Physiclan		23a. Part Enter the disease, or shoot or heart feilure. List	complications that cause only one cause on each	ed the deeth.	Do not ente	r tha moda of dyir	ng, such es cardie	ac or respiratory a	rrest,	Inte	proximete erval Batween aset and Deeth
1	/Medical Examiner		Immediate Cause (Fine) disaasa or condition resulting in deeth)	e se	pri	8					ó	Rdays
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	ocuted nd transit	Examiner	Sequentially list conditions,	r. Recu	Due to (or e	s e consequ	ence of):					
60,	icata be executed physician and s tha bunal-transit	al Ex	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or injury	· deal	betes	n	welli	Lus			į	
x 68760,	- O 0	Medical	thet initiated events resulting In death) Lest	d pace		s e consequ	ance of):	0				
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P.O.	0 0 %	hysi	Part II. Other significant condition	ne contributing to death t	but not resulti	ng in the un	derlying ceuse giv	en in Pert I.		Yes 2 No		e cause of death?
	uires than signed	by	gyoden	a gan	0	004	m		-	en eutopsy	24b. Were 6	Butopsy findings
Records,	sicien: The law requires that the cartificate has been signed by th firector, page 2 should be detache	Completed	COCON CO	arcinon		, 00	ikis.	8		ormed?	of daar	
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of V	Physician: this cartific ral director,	ToE	examiner?	Hospitai: 1 ☐ Inpeti	ient 2 EF	NOutpatient	3□ DOA Oth		Home 5 ☐ Resi		ar (Specify)	
Division o	Attending Phire death. ector: Attar th		27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investig	etion	ey Yeer)	8b. Time of Injury	28c. Injur Wor M 1			how Injury occur		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartific completely filled in by the funeral director,	Aedical	one) 2 Medical E	g Physician: To the best Examinar: On the basis o end manner st	of examination	edge, death on end/or inve	estigetion, in my o	pinion, deeth occ	e, end due to the urred et the time,	date end place,	and due to the	ceuse(s)
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State of Maryland / Department of Health and Mental Hygiene

		Certificate of D	Death Reg. No.	
		1. Decedent's Neme (First, Middla, Last)	2. Dete of Death 3. Time of Death	
	Physicia	JOHN DIDSCOMP	August 15 1999 8:05AM	
	/Medica Examine	An Franklike Name (Mant leathering about and aughter)	. City, Town, or Location of Death 4c. County of Deeth	
		Mariner Health Care of Southern Maryland	Clinton Prince George's	
	Funeral		If Under 24 Hrs. 8. Dete of Birth Hours Min. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (Steta or Foraign Country)	
	Director	579-48-1923 123 M 2 F 66 Yrs. Months Days	Sept. 22 1932 South Carolina	a
03	2 .	Usual Residence of Decedent		
3	d at d	10a. Stete 10b. County 10c. City, Town or Location Maryland Prince George's Distr	ict Heights 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
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	or 28ef s	10a. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?	
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65	mer death w r Neme 23a siner, must b	11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Yas or No- , Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc.	
20	72 hours sha natural, or its dical Examine		Specify: Specify: Black	
215-0020	al Es		ion 16b. Kind of Business/Industry	_
5	2 4	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done dur lifte. DO NOT use retired)	ring most of working	
212	1000	Elementary/Secondery (0-12) College (1-4or 5+) Truck Driv		
	be fled within 72 ho tal Hygiene. I other than "natur event, the Medical.	17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumame)	
GO .	Mental Mental sriked o	Elijah Lipscomb	Nellie Johnson	
ary	N DE S		nd Number or Rural Route Number, City or Town, State, Zip Code)	
2	and 2 saith a n 27 is ar tra	Emma L. Banks - Sister 3010 South Gro	ove, Upper Marlboro, MD 20774	
φ,	-111	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete 20c. Location - City or Town, Stete	
Ĕ.	Tages mt: # th ry or o	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans		
alti	P Indu	21. Signeture of Fureral Service Licensee 22. Name and Address	of Fecility	
m :	90119	1 1 S (2001 P	Stewart Funeral Home	
tre		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, of heart feiture. List only one cause on each time.	ing Rd., N.E. Wash., D.C. 20019 such as cardiac or respiretory errest, Approximete	
	hysician	shock of heert feilure. List only one cause on each line.	Interval Between Onset and Deeth	
	/Medical	Immediate Cause (Finel	al failing	
E	Examiner	disease or condition rasulting in deeth) a. Due to (or as a consequence of):	al failure 4 week	4
		Sen Panelson 1	DAUBOR + 1 714	
	our pure	Sequentially list conditions. Due to (or es a consequence of):	sworm su sof	_
o`	and I	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury	IL DAA	
68760	g physician and as the burdal-transit	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):		_
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Вох	e attending	d		
	0 0 2 7	Part II. Other atgniftcant conditions contributing to death but not resulting in the underlying causa given	n in Pert I. 23b. Dtd tobacco use contribute to the cause of death?	,
0	as been signed by the attendir as 2 should be detached for use		1 Yes 2 No 3 Probably 4 Unknown	n
	D o			
Records,	been si should		24e. Wes an autopsy performed? 24b. Ware eutopsy findings available prior to	
20	page 2 should		completion of cause of death?	
ac 3	page 1		1 Yes 2 No 1 Yas 2 No	
	nysician: ine law his certificate has but director, page 2 s	25. Was case referred/to medical	26. Place of Oeath (Check only one)	
>	r death. ector: After this certific by the funeral director.		4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
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-	within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier (Check only 2 Medicat Examiner: On the basis of examination and/or investigation, in my opin	, date end place, end due to the ceuse(s) end manner as stated.	
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	To To To To To To To To To To To To To T	29c. Signature and title of certifier 29c. License n	number 29d. Date signed (Mortifi, Day, Year)	
	2	2 > CW2 MD All endus D-	24535 8.17.99	
(3)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	IN DILLIFAL INV	
_		LAXMI BEILWH, 1700 OLD BRANCHT	VE, CLINTON, MD 20735	
	State Registrar	31. Data filed (Month, Day, Year) Registrar's Signature		

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** August 1999 12:00 AM LEE KOLAND 10 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner OF MARYLAND MEDICAL SYSTEM DALTIMORE UNIVERSITY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthpiace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 1**X** M 2□ F Yrs 218-92-8243 35 December 3,1963 Maryland Usuel Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Maryland | Prince George's Bowie 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3438 Estonia Drive 20716 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Merried 2 X Married 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4th Minister Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Joseph Ellis Lee Frances Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) De Lessert Lee/Wife 3438 Estonia Drive, Bowie, Maryland 20716 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 08/16 1999 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation B ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 Landover Road, Landover, Maryland 20785 23e. Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, show, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting In death) 1 hour Due to (or as a consequence of) Physician/Medical Examiner RRHYTHMIA Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of). Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE ρ 24b. Were autopsy findings available prior to Completed 24e. Was an eutopsy CONGESTIVE HEART FAILURE completion of ceuse of deeth? 1 Yes 2 No Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how Injury occurred 28b Time of Certification: 28a. Date of Injury (Month, Dey Year) 28c. injury at Work? 1 ANetural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) end menner as stated.

2 Medical Exeminer: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) UK JANG, MD. 22 SOUTH GREENE STREET BALTIMORE MARYLAND 21201 DUNG 32 Registrar's Signature

Registrar

31. Date filed (Month, Dey, Year)

AUG 1 7 1999

Funeral

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No.

2 Date of Death

3. Time of Deeth

Physician /Medical	MARK STEV	EN	LEW	S	Month	Day 19	Year	8:57p
Examiner	4a Facility Name (If not institution, give street and number THE Johns Hopkins	Hospita	_	4b. City, Town, or BALLIMON	e, City		of Death	
Funeral Director	5. Social Security Number 6. Sex 1 7. A 1	Age (In yrs. last bir 39	Yrs. If Under 1 Months C	fear If Under 24 Hrs lays Hours Min	Month, D	12,1960	9. Birthpl Count WEST	aca (Stete or Foreign try) VIRGINIA
with the Maryland a or 28a-f show be notified at Director	Usuel Residence of Decedent 10a. Stete WEST VIRGINIA JEFFERSON	10c. City, Tow	n or Location	SHEPHERDS	TOWN		10	0d. Inside City Limits 1 Yes 2 No
23a or 28a-fr ust be notifier ral Directo	10e. Street and Number 207 N. PRINCESS ST.		10f. Zip Co	25443		10g. Citizen of V	S.A.	try?
sif, or thems 23 Examiner must by Funeral	If Yes, Give	s? XNo	13. Wes Deceden If Yes, specify 1 Yes 2	t of Hispanic Origin? (: Cuban, Mexican, Puer No Specify:	Specify Yes or N to Rican, etc.)	o- 14. Race Blec Specify	e - America k, White, d	
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Examiner	disease or condition resulting in death)	Due to (or as a	consequence of):	CARCIN	10		- 1	MONTHS
ica associated burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	consequence of):	ER DISE	HZE			YEARS
at the death certificate be d by the attending physici etached for use as the bu Physician/Medical	that initieted events resulting in death) Last	Due to (or as a	consequence of):					
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use contribute to the cause of death? 3 Probably 4 Unknown □ No 24b. Were eutopsy tindings available prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? t ☐ Yes 2 No 1 Yes 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Certification: To Be Completed by P. Hospital or Attending Physician: The law requires tha ate has been signed page 2 should be de Division of Vital Records. After this certificate has 24 hours after death. filled in by the

1 Yes 2 No 27. Manner of Death
1 Natural
2 Accident 3 Suicide 4 ☐ Homicide 29a. Certifier (Check only one) 29b. Signeture and title of certifier

25. Wes case referred to medical examiner?

1 Decedent's Name (First Middle Lest)

5 Pending Investigation

6 Could not be determined

mo

28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

29c. License number RES-000

28c. Injury at Work?

1 Tyes 2 No

29d. Dete signed (Month, Day, Year) AUGUST 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UPPER GASTROINTESTINAL BLEED

28a. Dete of Injury (Month, Day Year)

JOHNS HOPKINS HOSPITAL 110 TOWER BALTIMORE, MD 21287 JAMES M SIZEMORE JR MD

State Registrar

31. Dete tiled (Month, Day, Year) AUG 1 3 1999

32. Registrar's Signature

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Physician /Medical Examiner

To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician and

Division of Vital Records, P.O. Box 68760,

ate hes been signed by the ettending physician end page 2 should be detached for use as the buriel-transit

Physician

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permit. Peges 1 and 2 should be filled within 72 hours after death with the Meryland Deportment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Evaluations must be not less

Baltimore, Maryland 21215-0020

Directo

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1 Neturel

Accident 3 Suicide 4 Homicide

29a. Certifier (Check only one)

29b. Signeture end title of certifier

29c. License number

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ateted.

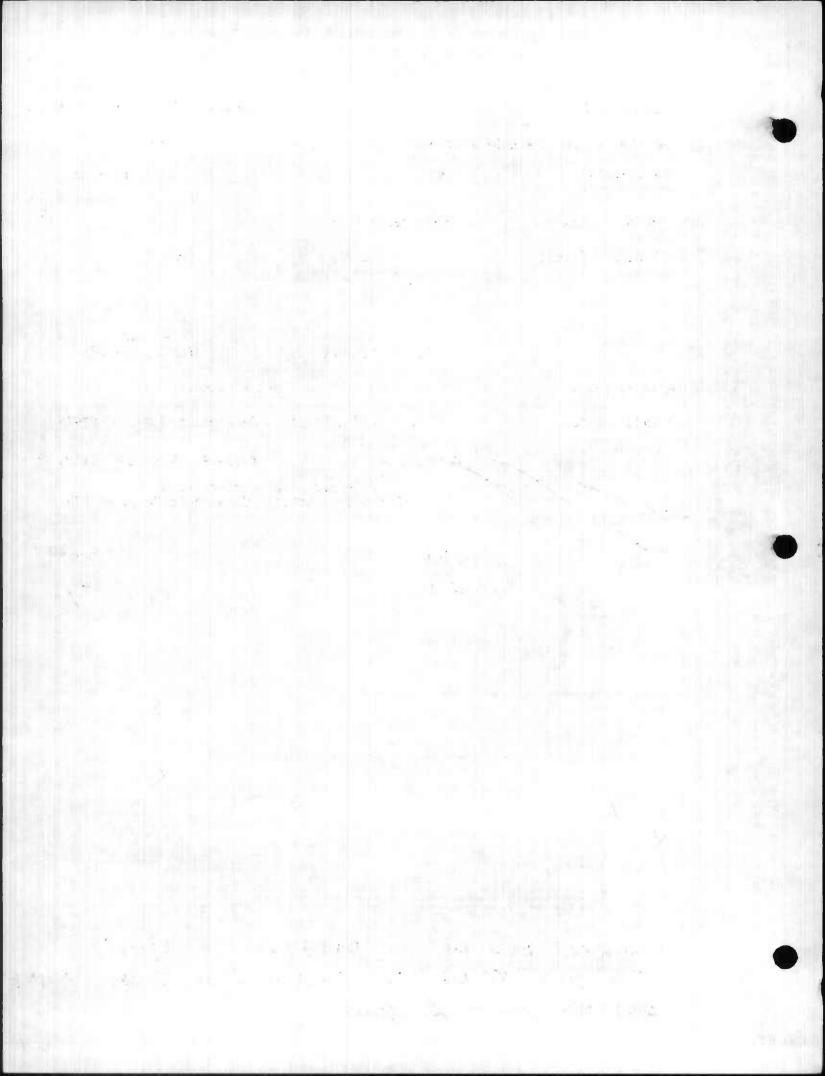
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete aigned (Month, Day, Year)

State Registrar

completely filled in by the funeral director,

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 4:35 p Eva Pauline A ugust 4b. City, Town, or Location of Death Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplaca (State or Foreign Country) 30X 1□M 2☐F Days 579-05-4035 Yrs. Director Ĩ905 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland . Calvert Sunderland 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 1930 Valley Lane 20689 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 No If Yes, Give Yaar or Dates: Be Completed by 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Bookkeeper Department Store 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Eugene Werking Unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Depertment of Health er Important: If item 27 fa any injury or other treu sncs. William E. Lewis/Son 5822 - 66th Ave., Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 8/14/99 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD 2 Ü 23a. Pert1. Enter the elsease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart dilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 2 Days Examiner Due to for es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last Due to (or as e consequence of) Due to (or as a consequence of). Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 - Homicide Medical 29a. Certifier i Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) on who completed ceuse of death (Jem 23a) (Type, Print) 30. Name and address Bouie MD LANT TOX 32 Registrar's Signature State Registrar

DHMH 16 Rev 6/95

10

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

the buriel-trensit

signed by the at d be detached fo

certificate

this

I Director: After this d in by the funeral di

To the Hospital within 24 hours e To the Funeral D

filed within 72 hours after death with the Maryland

?7 is marked other than "natural", or itema 23a or 28a-f show treumatic event, the Medical Examiner must be nothed at

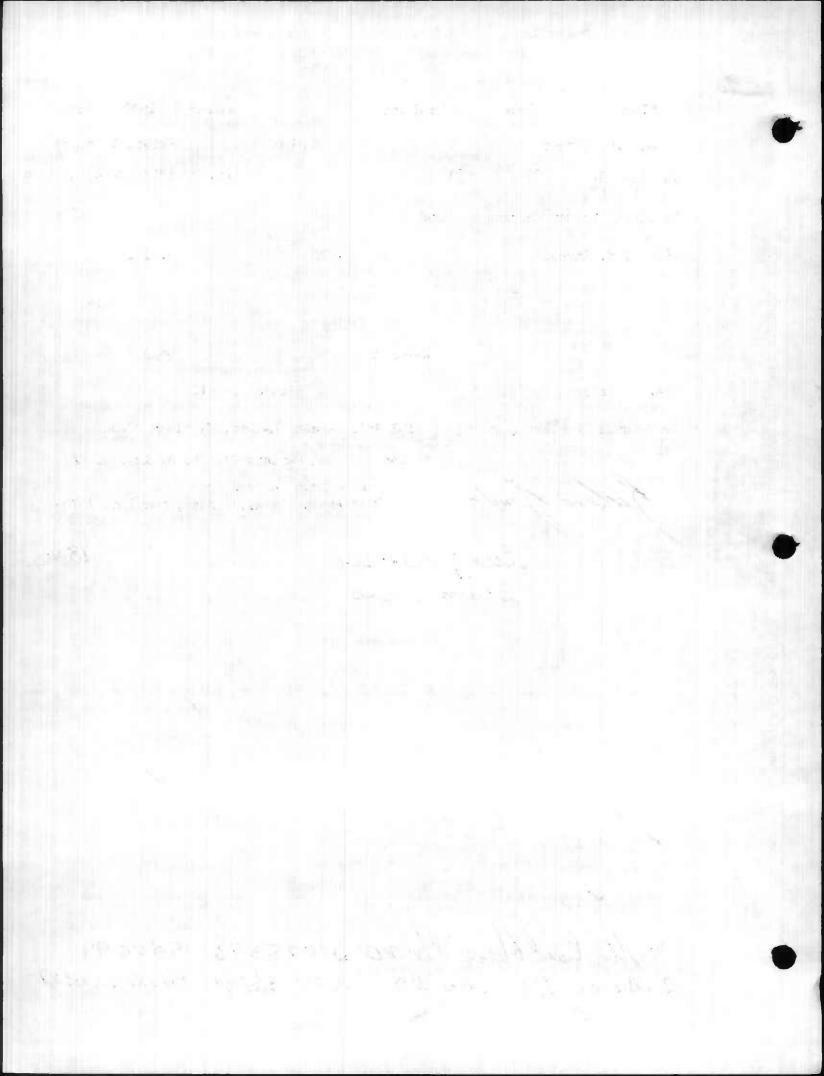
Peges 1 and 2 should be filed within nent of Health end Mental Hygiene. int: If item 27 is marked other than?

Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 9 7 4 9 5

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Physicia	an	Wilmer	Lee	Т	ambert			Month August	Day 13 199	Yaar O O•	30 PM
/Medic Examine	_	4a Facility Nama (If not institution, gir			ambert		4b. City, Town, or I		4c. County		JO 111
Examin	er	9103 3rd. Stree	- massau mac				Lanham		Drine	Coore	0.0
Funeral				ge (in yrs.	lest birthday)	If Under 1 Ye	ear if Under 24 Hrs.	8. Deta of Birth	FITHC	e George 9. Birthplace (State or Foreign
Director		235-18-0887 Usual Residence of Decedant	1∰ M 2□ F	81	Yrs.	Months Da	ys Hours Min.	8. Deta of Birth (Month, Day, Dec. 30	1917	West V	irginia
Maryland H ahow	tor	10a. Stata 10b. County Maryland Prince	Georges		ly, Town or Loc anham	ation					sida City Limits X Yas 2 □ No
r 28a	5	10e. Street and Number		1		10f. Zip Cod	le	10	g. Citizen of W	Vhat Country?	
N will	0	9103 3rd. Stree	t			20	0706		U.S.A		
IOFE, Maryland 21213-UU2U ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiena t of Health and Mental Hygiena If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examples must be incofined at	F	11. Marital Stetus 1 Navar Married 2 Married	if Yas, Giva			/as Decedent Yas, specify C	of Hispenic Origin? (S Cuben, Maxican, Puert No Specify:	pecify Yes or No- o Rican, atc.)		a - American Inc k, Whita, atc.	lian,
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Z1Z15-00Z0 d within 72 hours af giena. r than *natural;, or the Medical Evan	Completed by	15. Decedent's E (Spacify only highast gr Elemantary/Secondary (0-12)	ducation ada complatad) Collega (1-4or	5+)	16a. Decede (Give k lifa. D		cupation ona during most of wor tired)	king	USDA	sinass/Industry	
Hygie nt, II		17. Fathar's Name (First, Middla, Last	0		Resear	CII	18 Mother's Nen	na (First, Middla, N		e)	
Maryland 212 d 2 should be filed with th and Mental Hygiena. 7 ia marked other than traumatic event, me.	Be		*							,	
should ind Men in marke	2	Henry Lambert 19a. informant's Neme/Ralationship	(Time Print)		10h Maille	Addrage /St	reat and Number or Ru	Oswald	City or Town	State 7in Code	
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Baltimore, M permit. Pages 1 and 2 Department of Health Important: if item 27 is any injury or other tr	-	Georgianna Lamb	ert (Wite	20h F	Place of Dispos	3rd. Sition (Nama o	treet Lan	ham, Mary	Land 2	O/U6 City or Town, S	tata
Dallimore, semit. Pages 1 as Department of Hea mportant: if item any injury or othe		1 X Burial 2 ☐ Cramation 3			cematary, cram	atory or othar	place)				
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DEALCITY permit. Pag Department important: if any injury o		21. Signature Commerci Service Lice	1		22.	Rendon	Hale Fune	ral Home			
- 40101	_	lacand	mand-			9013 A	nnapolis R	d. Lanhan	Mary.	land 20	706
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/Medical Examiner		Immediata Causa (Final disease or condition	aller	19	now	001				1	8 Mas
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Ahysi the l	edicai	that initiated events resulting in death) Last		Dua to (c	or as a consequ	ence of):					
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ras that the designed by the a	Physician/M	Part il. Other eignificant conditione	contributing to death t	out not res	ulting in the un	derlying causa	givan in Part I.	23b. Did to	pacco uee cor	ntribute to the	cause of death?
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necords, P.O. DOX he law requires that the death cert e has been signed by the attendin- age 2 should be detached for use	þ									0.4h 14/2	An au fin din au
v require been si should	Completed							24a. Was ar perform	n autopsy ned?	evaileble	topsy findings prior to ion of causa
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ysician: The l	S							1 □ Ye	s 2 No	1 □ Yas	2□ No
Physician: The Physician: The this certificate ral director, page		25. Was casa rafarred to medical axaminar?					26. Placa of Dea	ith (Check only on	a)		
Oi Vital Physician: T this certificat ral director, pi	2	1 Yas 2 No	Hospitai: 1 ☐ inpati	ant 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	oma 5 PRaside	nce 6 Oth	ar (Specify)	
Ter the Ter th		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Data of tnju (Month, Da	iry ly Year)	28b. Tima of injury	28c. i	njury at Work?	28d. Dascribe ho	w injury occurr	red	
or Attending F after death. Director: After d in by the funer	Certification:	2 Acctdant investigation					1 ☐ Yes 2 ☐ No				
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State of Ma	ryland / D	epartment	of Health	and N	dental	Hygiene

Physician	1. Decedent'a Name (First, Middle, La	6-99 cr	OGITHIO	ate of Death	Reg.	. No.	3. Time of Death
/Medical	SADIE LANEY				08 10	Day 1999	9:09
Examiner Funeral Director	4a Facility Name (If not institution, given PRINCE GEORGE S. Social Security Number 579-07-3908	S HOSPITAL 7. Age (In yr	rs. lest birthday) If Ur 85 Yrs. Mont	CHEVERL	's. 8. Data of Birth	PRINCE GEO 9. Birth Cou 1914 GRE	olece (State or Foreign
M til	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Location				10d. Insida City Limits
ust be newfield at	Maryland Prince (9	Bladensburg	Zip Code	10g	. Citizen of Whet Cou	M∏ Yes 2 ☐ No
by Funeral	5425 Varnum St 11. Merital Status 1 Never Marriad 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates:		20710 accedent of Hispanic Origin? Ispecify Cuban, Mexican, Pue	(Specify Yes or No- orto Ricen, etc.)	USA 14. Race - Amari Black, White Specify: B	
ompleted	15. Decedent's E (Specify only highest gra Elementary/Secondery (0-12) 11th	ducation ade completed) College (1-4or 5+)	16e. Decedent's L (Give kind of life. DO NO Homemal	work done during most of w T use retired)	rorking 161	b. Kind of Business/li Own Home	
To Be	17. Father's Name (First, Middle, Last, Isaiah Damon V				ame (First, Middle, Mai cy Bethea	iden Sumeme)	
To Be C	19a. Informant's Name/Relationship (Christine Laney)		19b. Mailing Addi 5425 Val	ress (Street and Number or a	Rurel Route Number, Cadensburg,		
any injury of our	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Disposition (cemetery, cremetory Williams Fa	or other plece)		c. Location - City or T Gresham, S	
ouce.	21. Signatury of Funaral Service Licer		22. Name	and Addrass of Facility M Suitland Rd.			me of MD 20746
the burial-transit and lead of the second se	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	bDue to	O (or as a consequence (or as a consequence	of):	lator)	Second
etached for use as Physician/Mee	Death Other straidleast conditions	d.		Dod!	22h Did toho		to the cause of death
be detached by Physic	Pert II. Other significant conditions of	ontributing to death but not r	esulting in the underlyii	ng cause given in Fait i.		2 No 3 Pr	1/
Completed					24a. Was an a performe	ad?	Vere autopsy findings vailable prior to ompletion of ceuse f death?
To Be C	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3	26. Plece of D	Home (Check only one)	ce 6 □Other (Spec	ih)
the funere	27. Manner of Death 1 Natural 5 Pending Investigatio 3 Suicide 6 Could not b	28a. Date of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injury et Work?	28d. Describe how		
ai Certif	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	ocity)		City or Town,	Stata)	
Completely filled in by Medical Certifi	(Check only one) 2 Medical Exar	niner: On the basis of exami end manner stated.	netion end/or Investiga	29c, Licansa numbar	curred at the time, date	e end place, and due	to the ceusa(s)
	1/1/4	2000	7.	DOGGG		011	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. #30 PER DVR PER G774 8-3 State Wef Maryland / Department of Health and Mental Hygiene AMEND ITEM: #20B PER F.H. 8-30-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DWAIN EVERETT LUCAS 08 99 22 5:20 a.m. 4a. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death HCR MANOR CARE PRINCE GEORGES T.ARGO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Dev. Year) Birthplaca (Stete or Foreign Country) 1 □ M 2 □ F 62 Yrs 291-30-3118 12/29/1936 OHIO Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits TY Yes 2 No MARYLAND PRINCE GEORGES FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7300 LEONA STREET 20747 12. Was Decedant Evar in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. NTYes 2□ No HYes, Give Year or Datas: Veitnam 1 Navar Married 2 Married 1 ☐ Yes X☐ No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Dealership Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Sumeme) WILMA DOROTHY BATES CLARENCE WILLIAM LUCAS 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 7300 LEONA ST. FORESTVILLE, MD 20747 VERNICE LUCAS 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 X Burlai 2 ☐ Cremation 3 ☐ Removal from State 8/25/99 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA MOUNT COMFORT 21. Signature of Funeral Service Licensea 22. Nama and Addrass of Facility CUNNINGHAM FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallure. List only one cause on each line. Approximate Interval Between Onsat and Death Lung Canch immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daeth) Last Due to (or as a consequence of): Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yas 2 ☐ No 1 Yaa 2 No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

pemit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Introportant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, If a Meucal Examiner must be contracted.

Baltimore, Maryland 21215-0020

the burisi-tran 88 cedificate has 175 (ELBO) Attac I or Attend after deat Director.

The law requires that the death certificate be expr

Athending

Box 68760,

Division of Vital Records, P.O.

Physician/Medical Examiner þ Completed Be

To the Hospital (within 24 hours a To the Funeral D State Registrar

Certification: To 27. Manner of Death 1 Zi Naturai Medical 29a. Certifie

29b. Signature and title of cartifier

5 Pending invastigation

6 Could not be determined

1 Yes 2 No

2 Accident

3 ☐ Sulcide

4 Homicide

(Check only one)

anong, MD

Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

29c. Licansa number 20108

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

99

28t. Location (Street end Number or Rural Route Number, City or Town, State)

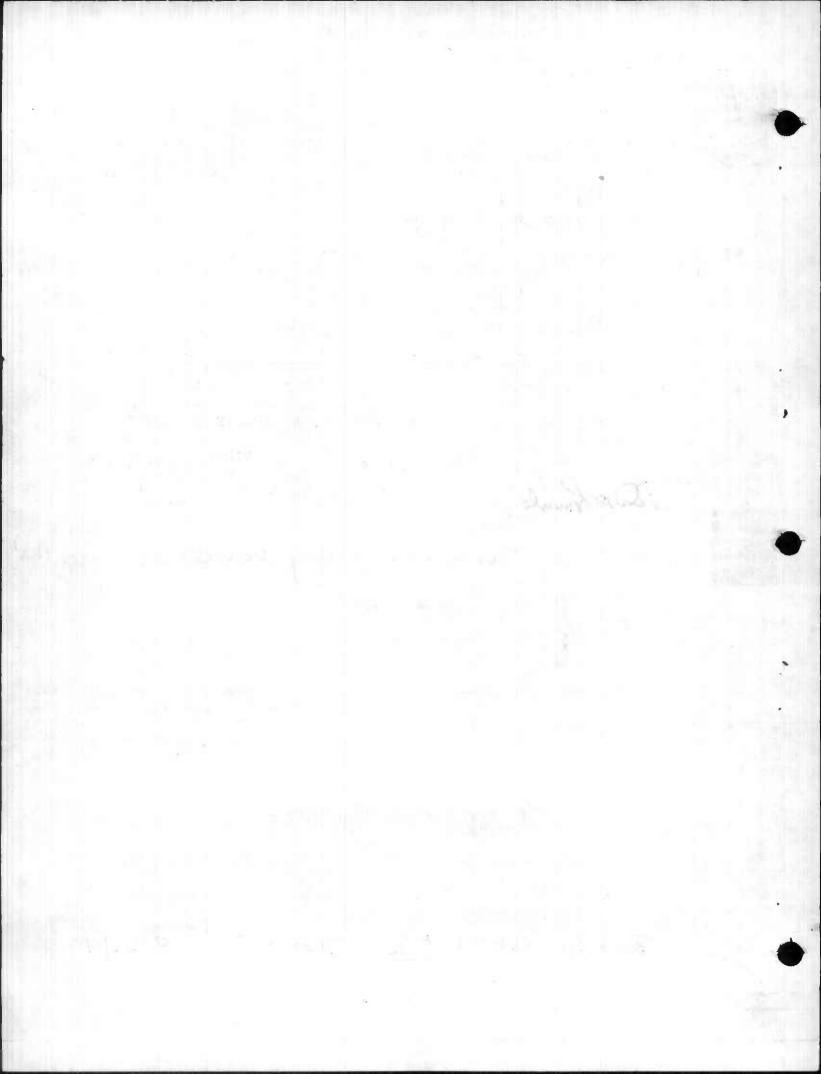
4 Nursing Homa 5 ☐ Residenca 6 ☐ Othar (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH ARORA 1400 GALLANT FOX LANE MD 20715

31. Date tiled (Month, Day, Year) SEP 0 1 1999 32. Registrar'a Signature



			Certificate o	f Death		Reg. No.	274	18
Decedent's Name (First, Middle, L Wesley R. M		v .Tr			2. Date of De Month	Day	Year 7 - 4.4	
Facility Name (If not institution, g				4b. City, Town, or	Augus Location of Death		999 7:44	A.M.
				Chesapea	ake City			
Social Security Number 6.10-42-4875	Sex 7. A 10 M 2 F		Months Day	ar If Under 24 Hrs	8. Date of Bird Month Da	1 7° 195	9. Birthplaca (State of Phila.)	Pa
al Residence of Decedent								
	Cecil	1		City				Ity Limits
. Street and Number			10f. Zip Code)		10g. Citizen of V	Vhat Country?	
279 Town Poi	nt Rd.		2	1915		USZ	A	
	Armed Forces 1/ Yes 2 If Yes, Give	? No Vietnam	13. Was Decedent of If Yes, specify Control of Yes 2 □XN		Specify Yes or No to Rican, etc.)		ck, White, etc.	
15, Decedent's I	Education			cupation	dian	16b. Kind of Bu	usiness/Industry	
(Specify only highast g		5+) Ow:	ille. DO NOT use reti ner & Ope	erator	rking	Constru	action Co	
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		R. A.	Ferris	& Co. 8	/18/99	West (Chester,	Pa.
Signature of Femoral Service Lice	Lec							
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quentially list conditions, ny, leading to immadiate ise. Enter Underfying use (Disease or Injury t initieted events ulting in death) Last	c							
ii. Other eignificant conditions	contributing to death	but not resulting in	the underlying cause	given in Part t.	23b. Did	tobacco use co	ntribute to the cause	of death?
					10	Yea 2 No	3 ☐ Probably 4 🕅	Unknown
					24e. Was	an autopsy rmed?	24b. Were autopsy available prior completion of of death?	to
					1981	Yes 2□No	15 Yes 20	No
				26. Piace of De	eth (Check only o	one)		
Was case reterred to medical axaminer?							er (Specify)	
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axaminer? 1 Na 2 No Manner of Death Block State Sta	28a. Date of Ini (Month, D	ury 28b. Ti	me of jury M 1	ijury at Vork?	28d. Describe	how injury occur		
axaminer? 1 DX as 2 No Manner of Death Thetural 5 Pending	28a. Date of Ini (Month, D	ury 28b. Ti	me of Juny 28c. In	ijury at Vork?	28d. Describe	how injury occur Street and Numb	red per or Rural Route Nun	nber,
axaminer? 1	28a. Dete of In (Month, D) 28a. Plece of Ir building, e	njury - At home, far ntc. (Specify) 1 of my knowledge, of examinetion and	me of jury M 28c. In jury M 1 m, street, tectory, office deeth occurred et the	4 Nursing I	28t. Location (City or Total	Street and Numb wn, Stete)	per or Rural Route Nun	
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The state of the s	279 Town Point 10-42-4875 11 Residence of Decedent State 10b. County Md. Street and Number 279 Town Poi Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest glemantary/Secondary (0-12) Father's Name (First, Middle, Latwest Name/Reletionship bynthia M. Wi Informant's Name/Reletionship bynthia 2 Peremation 3 4 Donetion 5 Other (Specify only highest glemantary/Secondary (0-12) Method of Disposition 1 Burial 2 Peremation 3 4 Donetion 5 Other (Specify only highest glemantary) Signature of First, Middle, Latwest glemantary A Donetion 5 Other (Specify only highest glemantary) A Donetion 5 Other (Specify only highest glemantary) Burial 2 Peremation 3 A Donetion 5 Other (Specify only highest glemantary) Burial 2 Peremation 3 A Donetion 5 Other (Specify only highest glemantary) Burial 2 Peremation 3 A Donetion 5 Other (Specify only highest glemantary) Burial 2 Peremation 3 Burial 2 Peremation 3 A Donetion 5 Other (Specify only highest glemantary) Burial 2 Peremation 3 Burial 2	Cocial Security Number 6. Sex 10 - 42 - 4875 10 M 2 F 7. A 10 M 2 F 10 M 2 F	Companies Comp	10 - 42 - 4875 10 M 2 F 7. Age (In yrs. last birthday) 11 Under 1 Ye 10 - 42 - 4875 10 M 2 F 7. Age (In yrs. last birthday) 11 Under 1 Ye 10 - 42 - 4875 10 M 2 F 44 Ayrs. 10 Months Day Chesapea	Chesapeake City Chesapeake	Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security Number Cocial Security State Cocial Security Number Cocial Security Numb	Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Cecil Cecil Chesapeake City Chesapeake City Cecil Chesapeake City Cecil Chesapeake City Chesapeake C	

Registrar

AUG 1 8 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Deeth **Physician** 11LLER August 20, 1999 4c. County of Death 10:40 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner BAUTIMORE CITY
H Under 1 Yeer H Under 24 Hrs. 8. Date of Birth (Month, Pay, Ye)
OCT 13 BAUTIMORE HOPKINS HOSPITA(5. Social Security Number Birthplace (State or Foraign Country) 7. Age (In vrs. last birthday) **Funeral** 1919 11 M 2□ F Months 79 Yrs. 220-32-7716 Maryland Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Kent Director Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14120 Roberts Dr. Funeral 21635 death U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 21215-0020 White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Maryland State Elementery/Secondary (0-12) Collega (1-4or 5+) Laborer 6 Highway Adm. Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Charles A. Miller Lena Atkinson 19a. tnforment's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Nellie Pippin (sister) P.O. Box 93 Galena, MD. 21635 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State Capitol Crematory 8-23-99 Dover, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fameral Service Cicus 22. Name end Address of Fecility M00510 Galena Funeral Home of Stephen Schaech 21. Pert1. Phile the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one causa on each line. Intarvel Batween
Onset and Death **Physician** /Medical Immediete Ceuse (Finet diseese or condition resulting in daath) NEUMONIA TWO WEEKS Examiner Dua to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death cardificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one please. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings eveilable prior to 24a. Was en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No Division of Vital 25. Was case reterred to medical Be 26. Place of Deeth (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Medical Certification: To 27. Mapnar of Deat Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Natural 2 Accidant Natural 1 Yes 2 No 8 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of tnjury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida 29e. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred et the time, data and place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, daath occurred at the time, dete end place, and due to the cause(s) and menner steled. 29b. Signeture end titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) RES-000 3 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rsv 6/95

State Registrar

TAMES

31. Dete tited (Month, Day, Year)

JR MD

JOHNS HOPKINS HOSPITAL

SIZEMORE

32. Registrer's Signetura

